Health Care Financing

Program Statistics

Medicare and Medicaid Data Book, 1986

Health Care Financing Administration

Health Care Financing

Program Statistics

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of HCFA is to promote the timely delivery of appropriate and quality health care to the 29.0 million Medicare enrollees and the 21.6 million Medicaid recipients among the Nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Bureau of Data Management and Strategy (BDMS) operates HCFA's statistical data systems and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

The Office of the Actuary (OACT) directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The Medicare and Medicaid Data Book, 1986 is the third edition of a report that provides an overview of the Medicare and Medicaid programs. This report presents basic data and analyses of the programs. It includes trends on enrollees, recipients, use of services and expenditures, and describes various aspects of the two programs. It also provides lists of Medicare carriers and intermediaries, Medicaid agencies and fiscal agents, and Agency offices to call for information.

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Medicare and Medicaid Data Book, 1986

by Martin Ruther, Aileen Pagan-Berlucchi, Kim Wivell, and Chris Howe

Executive summary

This volume is the fourth in a series of descriptive statistical reports on the Medicare and Medicaid programs. Medicare data for calendar year 1982 and Medicaid data for fiscal year 1983 are presented. The volume is intended to serve as a resource for public officials, researchers, policy analysts, and consumers who have an interest in these health programs.

The report has four chapters. In Chapter 1, brief overviews of Medicare and Medicaid are provided and information is presented on the relationship between these two programs, Federal administration of the programs, and comparative program expenditures.

Medicare and Medicaid program highlights from Chapter 1 include the following:

- Combined Medicare and Medicaid payments may reach $132 billion by fiscal year 1988, according to estimates from the Office of Management and Budget. Medicare benefit payments are estimated to account for $85 billion of the total and Medicaid assistance payments to account for $48 billion. It is estimated that the average annual rate of increase of Medicare payments from fiscal year 1983 to fiscal year 1988 will be 8.8 percent, and Medicaid payments will increase by 8.1 percent.
- The Office of the Actuary (OACT) preliminary estimates of Medicare benefit payments by type of service indicate that inpatient hospital payments constituted the largest category. These payments increased 9 percent from fiscal year 1984 to fiscal year 1985. The small size of the increase, which is less than that for any other major service, is probably attributable to the Medicare prospective payment system. Next in order of size of payment were physician payments, which rose 12.2 percent in the same period, followed by outpatient services, up 25 percent.
- OACT estimated, by size of Medicaid payments, that intermediate care facility services increased 12 percent from fiscal year 1984 to fiscal year 1985, followed by inpatient hospital payments, 8 percent, and skilled nursing facility payments, 6 percent.
- In calendar year 1982, 18.8 million of the 29.5 million aged and disabled Medicare enrollees had $47.7 billion paid on their behalf for health services. In fiscal year 1983, 21.5 million Medicaid recipients (persons who received Medicaid services) had $32.4 billion paid on their behalf.
- In calendar year 1982, the average Medicare payment per reimbursed enrollee was $2,534. The average Medicaid payment per recipient was $1,505 in fiscal year 1983.
- Two-thirds of total Medicare reimbursements in calendar year 1982 were for inpatient hospital care. In contrast, the emphasis in Medicaid is on long-term care, and 43.5 percent of Medicaid payments in fiscal year 1983 were for care in intermediate care facilities and skilled nursing facilities.
- Medicare eligibles were mostly aged persons (90 percent of all enrollees), and the aged received 87 percent of all reimbursements in calendar year 1982. The remainder were disabled enrollees, including persons with end stage renal disease.
- The largest proportion of Medicaid recipients were children and adults who became eligible through the Aid to Families with Dependent Children (AFDC) program. Persons covered through AFDC comprised 69 percent of all recipients but received only 26 percent of all payments in fiscal year 1983.
- In calendar year 1984 (the latest year for which data are available) Medicare paid 48.8 percent of all personal health care expenditures of the aged, and Medicaid paid 12.8 percent.

Trends in the evolution of the Medicare and Medicaid programs are reported in Chapter 2. Trends are described for the number of Medicare enrollees and Medicaid recipients, Medicare and Medicaid expenditures, and the use of and expenditures for hospital inpatient and physicians' services in both programs. Trend data are also presented for other services in each program, including Medicaid long-term care utilization and expenditures. A time series of Medicare deductibles and coinsurance amounts is presented. The chapter ends with a review of current issues concerning the programs and the health sector.

Highlights of Medicare and Medicaid program trends reported in Chapter 2 include the following:

- From 1966 to 1982, the number of Medicare enrollees (including the disabled after coverage for them began in July 1973) increased at an average annual rate of 2.7 percent a year. The average age of aged Medicare enrollees also increased. The proportion of enrollees 75 years of age or over grew faster than the proportion 65–74 years of age. This gradual aging has long-term effects because older enrollees are relatively high users of health care services and raise the average amount reimbursed per enrollee.
- From fiscal year 1973 to fiscal year 1983, the number of Medicaid recipients increased 0.9 percent per year. This overall upward trend included periods of both growth and decline.
- Total Medicare benefit payments grew 17.5 percent per year from 1967 to 1982.
- Total Medicaid expenditures increased at an average annual rate of 14.1 percent from 1973 to 1983.
- From 1967 to 1982, Medicare reimbursements for inpatient hospital services increased from 62.7 percent to 66.5 percent of total reimbursements. The

Elvira Fussell contributed to the preparation of the tables in this report.

proportion of reimbursements for skilled nursing facility services decreased from 6.5 percent to 0.9 percent in the same period.

- Among aged persons enrolled at any time during 1982, persons reimbursed $15,000 or more represented only 1.9 percent of enrollees but accounted for 31.3 percent of Medicare reimbursements for the aged.
- In contrast, among disabled Medicare enrollees enrolled at any time during 1982, 3.4 percent were reimbursed $15,000 or more, and this group accounted for 48.1 percent of all reimbursements for the disabled. Also, 45.2 percent of the disabled received no reimbursement.
- In fiscal year 1983, aged, blind, and disabled recipients accounted for 29.3 percent of all Medicaid recipients but accounted for 72.2 percent of all Medicaid payments. Children in the Aid to Families with Dependent Children category accounted for 43.8 percent of all Medicaid recipients but only 11.8 percent of all Medicaid payments.
- According to the Medicare archival reimbursement abstract, in 1974, the first full year of Medicare coverage for patients with end stage renal disease (ESRD), reimbursements for ESRD enrollees were $229 million. By 1982, reimbursements for ESRD patients were $1,650 million, an average annual increase of 28 percent.
- In contrast, reimbursements per ESRD enrollee rose from $14,300 in 1974 to $23,300 in 1982, an annual growth rate of only 6.3 percent. This is largely because there has been a limit on charges for kidney dialysis treatments.
- Medicare enrollees paid $2.9 billion in hospital insurance (HI) cost sharing and $5.4 billion in supplementary medical insurance (SMI) cost sharing in calendar year 1982.
- From 1977 to 1982, HI cost sharing for aged and disabled enrollees rose at an average annual rate of 22 percent, and SMI cost sharing averaged more than 16 percent.

In Chapter 3, the major characteristics of the Medicare program are described and program statistics are provided. Medicare eligibility, benefits, financing, and administration are outlined for both the hospital insurance and supplementary medical insurance programs. Data are presented on enrollment and expenditures for the aged and disabled. Detailed information is provided on Medicare financing and administration, the use of Medicare benefits, and the distribution of reimbursements for various services by different categories of enrollees. For the first time, data are presented by diagnosis-related groups. The chapter concludes with a description of Medicare's arrangements with health care prepayment plans and health maintenance organizations and with a discussion of the Medicare statistical system, including a description of data on reimbursement for physicians and other suppliers of services.

Highlights from Chapter 3 follow.

Persons served and reimbursement per person, 1982

- Much larger proportions of aged and disabled enrollees received supplementary medical insurance benefits than hospital insurance benefits. However, for both groups, average payments per person served were far higher for HI than for SMI.
- The proportion of aged enrollees receiving various types of Medicare benefits was successively higher with increasing age. By far the largest proportion of aged enrollees received physicians' services, followed by outpatient and then inpatient hospital services.
- By race, larger proportions of aged white persons received Medicare benefits for inpatient hospital, skilled nursing, and physicians' services. Aged persons of all other races received greater proportions only for outpatient and home health services.
- Aged persons of all other races had higher reimbursements per person served than white persons had for all services except physicians' services.
- Except for inpatient hospital benefits, a larger proportion of aged women than aged men received benefits.
- Reimbursement per aged person served was highest for inpatient hospital services ($4,391), followed by skilled nursing facility services ($1,591) and home health agency services ($926). Comparable figures for SMI services were $631 for physicians' services and $265 for outpatient services.

Hospital insurance benefits, 1982

- For both aged and disabled enrollees, short-stay hospital discharges per 1,000 enrollees and covered days of care per 1,000 enrollees increased with age.
- The discharge rate for both aged and disabled white persons exceeded that for persons of all other races. However, aged and disabled persons of other races had longer average lengths of stay and higher charges per discharge than white persons.
- The proportion of the aged who received skilled nursing facility (SNF) benefits was more than three times higher than that of the disabled.
- Among both the aged and the disabled, higher proportions of females than males received SNF benefits.

Prospective payment system

- The total number of enrollees discharged from short-stay hospitals in 1984, the first full calendar year of the prospective payment system, decreased substantially, 8.1 percent, from the prior year. In the same period, the average length of stay fell a full day, a record decrease.

Supplementary medical insurance benefits, 1982

- The proportion of persons using physicians' services was similar for aged and disabled enrollees. However, average reimbursements per person served were nearly one-third higher for disabled than for aged persons.
- For aged and disabled enrollees combined, the reduction in reasonable (allowed) physician charges made by Medicare carriers was 24.4 percent.
- Among the aged, Medicare reimbursed 64.9 percent of physicians' charges due (total charges less the reduction amount on assigned claims). The remainder, 35.1 percent, was the liability of the Medicare patient. It consisted of coinsurance, 15.8 percent; the reduction on unassigned claims, 13.1 percent; and the deductible, 6.2 percent.
- For outpatient services, both the proportion of persons reimbursed and the average reimbursement were higher for disabled than for aged enrollees. This reflected, in part, the use of dialysis services by disabled enrollees with ESRD.

Group plans

- As of March 1984, only 3 percent of the total Medicare population were members of health care prepayment plans or health maintenance organizations.

Detailed data on the Medicaid program are reported in Chapter 4. Descriptions of Federal rules and State options are followed by information on State provisions for eligibility and benefits. Statistical data are presented on service use and expenditures for each Medicaid jurisdiction. During the development of this publication, when Federal and State Medicaid data were found to differ, State data were used. Hence, the data in this publication may differ slightly from those in other Health Care Financing Administration publications.

Chapter 4 also contains descriptions of Medicaid financing and administration, including matching rates for Federal financial participation, recipients and expenditures under State "buy-ins" to Medicare, number of certified providers, adoption of Medicaid Management Information Systems, Federal medical assistance percentages, and the Medicaid data system. For the first time, cost data are presented from the evaluation of the first 2 years of operation of the Arizona Health Care Cost Containment System (AHCCCS).

Highlights from Chapter 4 follow.

Number of Medicaid recipients and payments, fiscal year 1983

- Of the 21.5 million total Medicaid recipients, 73.1 percent received cash assistance. These recipients accounted for 52.8 percent of total vendor payments.
- Although 69 percent of all recipients were in the AFDC-related group, they accounted for only 25.7 percent of all vendor payments.
- The disabled accounted for 34.6 percent of total payments but only 13.8 percent of total recipients.
- Female recipients accounted for 64.1 percent of all recipients. Females also accounted for the larger share of total vendor payments (65.9 percent).

Service coverage and limitations

- In fiscal year 1983, recipients 65 years of age or over accounted for the largest share of total vendor payments (37.0 percent) but represented only 15.1 percent of all recipients.
- Among reporting States, 30.1 percent of all vendor payments for fiscal year 1983 were for inpatient hospital services (including general and mental hospitals), followed by intermediate care facilities (ICF's), 29.2 percent, and SNF's 14.3 percent.
- As of October 1, 1985, the most frequently offered optional services, by the number of States and territories offering them, were prescribed drugs (51) and optometrists', clinic, and ICF services (50 each).
- In March 1984, 45 States (including the District of Columbia) limited inpatient hospital services, 40 States limited outpatient hospital services, and 45 limited physicians' services. Thirty-four States limited services covered in ICF's, and 28 either did not offer or limited services covered in ICF's/MR.

Federal Medicaid assistance percentage

- The Federal share of State medical vendor payments is based on State per capita income. From fiscal year 1984 to fiscal year 1985, 17 States received the minimum Federal Medicaid assistance percentage of 50 percent; Mississippi, the State with the lowest per capita income, received the highest, 77.6 percent.

Arizona Health Care Cost Containment System

- In fiscal year 1983, the AHCCCS program cost $1.8 million more than it is estimated that the Medicaid program would have cost. In fiscal year 1984, however, AHCCCS program savings were $3.2 million.

This volume contains several appendixes that are designed to facilitate understanding of the material and identify additional sources of information. Names and addresses are listed for Medicare intermediaries and carriers. Telephone numbers are supplied for Medicaid State agencies and medical assistance programs and for the Health Care Financing Administration offices responsible for various facets of the Medicare and Medicaid programs. A glossary and list of acronyms used in this report are also included.

1. Introduction to Medicare and Medicaid

In this chapter, the major characteristics of the Medicare and Medicaid programs are outlined. Information is also presented on the relationship between the two programs, including descriptions of coverage for persons eligible under both programs (dual eligibles). In addition, material is provided on how the Federal Government is organized to administer both programs and how much each program spends (in total and per enrollee or per recipient) in each State.

Overview of Medicare program

The Medicare program covers hospital, physicians', and other medical services for most persons 65 years of age or over, disabled persons entitled to social security cash benefits for at least 24 months, and most persons with end stage renal disease. Total Medicare benefit payments (reimbursements and other payments from Medicare trust funds) totaled $51.1 billion in calendar year 1982.

Medicare has two complementary but distinct parts: hospital insurance (HI), also called Part A, and supplementary medical insurance (SMI), also called Part B. The HI program covers 90 days of inpatient hospital care in a benefit period (spell of illness), which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 consecutive days. There is no limit to the number of benefit periods an individual may use. The program also provides a nonrenewable (lifetime) reserve of 60 days if a beneficiary exhausts the 90 days available in a benefit period.

In addition to inpatient hospital care, the HI program covers up to 100 posthospital days in an SNF if the beneficiary is certified to require such care. The HI program also covers home health agency visits. Effective July 1981, home health agency visits do not require prior hospitalization, and the previous limit of 100 visits was removed by the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499).

About 95 percent of the Nation's aged are enrolled in the HI program. On July 1, 1966, when Medicare became operational, 19.1 million aged persons were enrolled. By July 1, 1983, the number of enrollees had increased to 30.0 million; this total included 2.9 million disabled enrollees. (Medicare coverage of the disabled began on July 1, 1973.)

Nearly everyone covered by HI voluntarily enrolls in SMI. Unlike HI, SMI requires a monthly premium payment, $17.90 per month as of January 1987. Under buy-in agreements, most State Medicaid programs pay these premiums for persons who qualify for both Medicaid and Medicare benefits. The SMI program provides payments for physicians as well as related services and supplies ordered by physicians. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

Several health care services that the aged generally use, such as routine eye examinations and preventive services, are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. Also, neither intermediate nursing care nor long-term nursing care is provided.

Both the HI and SMI programs require beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible for each benefit period. This deductible ($520 in 1987) is determined each year by the Secretary of Health and Human Services. The coinsurance amount is based on the inpatient hospital deductible. Coinsurance equal to one-fourth of the hospital deductible is required for the 61st through 90th day of inpatient hospital care; an amount equal to one-eighth of the deductible is required for the 21st through 100th day of SNF care; and an amount equal to one-half of the deductible is required for the 60 lifetime reserve days for inpatient hospital care. The patient is also liable for the cost or replacement of the first three pints of blood in a benefit period.

Under SMI, in addition to paying a monthly premium, the beneficiary must pay a $75 deductible each year. (The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, raised the deductible from $60 to $75, effective January 1, 1982.) On each claim for payment, physicians can accept or reject assignment. Acceptance of assignment means the physician agrees to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed (reasonable) charges directly to the physician. Beneficiaries are liable for the remaining 20 percent of allowed charges (coinsurance). On unassigned claims, the beneficiary is also responsible for the difference between the physician's charge and the allowed charge. (Benefits under SMI are discussed in more detail in Chapter 3.) The Medicaid program assumes cost sharing for Medicaid beneficiaries covered under "buy-in" agreements. (As of calendar year 1982, 46 States had a buy-in program.) The buy-in program is discussed in more detail later in this chapter.

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered under the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and from general revenues of the Federal Government.

Overview of Medicaid Program

Medicaid is a federally supported and State-administered assistance program providing medical care for certain low-income individuals and families. Medicaid accounted for $32.4 billion in Federal and State expenditures for medical services in fiscal year 1983.

The program is designed to provide medical assistance to people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act: Title IV-A, the program of Aid to Families with Dependent Children, or Title XVI, the Supplemental Security Income program for the aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. (Chapter 4 contains a more detailed discussion of the major differences among jurisdictions in the criteria used to determine program eligibility.) In addition, States may provide Medicaid to the medically needy, that is, people who:

- Fit into one of the categories of people covered by the cash assistance programs (aged, blind, or disabled individuals or members of families with dependent children when one parent is dead, absent, incapacitated, or, at State discretion, unemployed).
- Are not recipients of cash assistance but have income, after deducting medical expenses, that falls below certain levels.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, SNF services for individuals 21 years of age or over, home health services for individuals eligible for SNF services, physicians' services, family planning services, rural health clinic services, nurse-midwife services, and early and periodic screening, diagnosis, and treatment services for individuals under 21 years of age. In addition, States may elect to provide a number of other services, including drugs, eyeglasses, private-duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care.

Medicaid is a vendor payment program; payments are made directly to providers of service for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement levels as full payment. Individuals in long-term care institutions must turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. Prior to the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), States could not require the categorically eligible to share costs for mandatory services, but they could require other Medicaid recipients to share in the cost of certain services. However, the act permits States to require cost sharing of certain categorically eligible recipients.[1] As noted earlier, most State Medicaid programs have buy-in agreements with Medicare. Under these agreements, Medicaid pays the Part B Medicare premiums and cost sharing for persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions vary with States' per capita income and currently range from 50 percent to 78 percent of program medical expenditures. Administration, fraud and abuse program, and Medicaid Management Information System costs are matched at other rates.

States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs.[2] The District of Columbia, Puerto Rico, Guam, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. Some States also include persons not eligible for Federal matching (State-only or medically indigent persons) in their medical assistance programs but receive no Federal contributions for the costs of their care. As a result, the characteristics of Medicaid programs vary considerably from State to State.

Comparison of Medicare and Medicaid

Data

The marked differences in the statistical systems supporting the Medicare and Medicaid programs obviously limit comparisons of the two programs. In this section, some differences between the data of the two statistical systems presented in this report are discussed.

The Medicare statistical system collects data on enrollees, that is, persons eligible for Medicare. In addition, data are shown for enrollees who received services for which reimbursements were made (referred to as persons served). In contrast, Federal Medicaid statistics consist of aggregate counts of the number of recipients (as opposed to enrollees) and dollars expended on covered services.

Most of the Medicare statistics in this report are produced from the Medicare statistical system, which contains the universe of claims that are processed in the Central Office of the Health Care Financing Administration (HCFA) in Baltimore. The Central Office also tabulates data on the services used by each person reimbursed. Medicaid statistics also are maintained in the Central Office, but only after they have been aggregated into recipient and expenditure counts by the

[1] The act also made a number of other changes in the Medicaid program, such as allowing for coverage of home care for certain disabled children and the establishment of a Medicaid program in American Samoa.

[2] The Arizona Health Care Cost Containment System became effective on November 9, 1981. This program provides some health care to some of the poor based on a prepaid capitated basis. This system currently is being run as a demonstration program supported by the Health Care Financing Administration.

States. These data are reported to HCFA by the Medicaid jurisdictions annually. Unlike most Medicare data, HCFA data on the Medicaid program cannot be disaggregated by individual person. Thus, Medicaid statistics are more limited in use than Medicare statistics.

Medicare claims data are generally reported for the calendar year in which medical services were rendered rather than the date when Medicare payment was made. Conversely, Medicaid recipient and expenditure counts included in the following tables were reported for the fiscal year in which services were paid. More information on the Medicare and Medicaid data systems is contained in Chapters 3 and 4, respectively.

Dual coverage

Through State buy-in agreements, about 11 percent of aged and disabled SMI Medicare enrollees were also covered by State Medicaid programs in calendar year 1983. States can obtain SMI coverage for these dual eligibles under buy-in agreements with Medicare. States that buy in pay the SMI premium and are responsible for Medicare cost sharing. When persons are eligible under both programs, Medicare is the primary payer for Medicare services, and Medicaid pays the deductible and coinsurance. States receive Federal matching payments for these expenditures. Although States may buy into Medicare for any of their Medicare-Medicaid eligibles, they receive Federal matching funds on premium payments only for persons receiving cash assistance (the categorically needy). States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal matching payments for services that would have been covered under SMI. Among States and jurisdictions with Medicaid programs (all States except Arizona), 48 States and jurisdictions had buy-in agreements as of calendar year 1983; 4 States and 1 jurisdiction did not (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico).

State Medicaid programs provide many services for the aged and disabled that are not provided by Medicare, including SNF care beyond the 100-day posthospital benefit provided by Medicare, long-term care in intermediate care facilities (ICF's), prescription drugs, eyeglasses, and hearing aids. In terms of the range of benefits that a State may provide, Medicaid is more comprehensive than Medicare.

Medicaid also has a more pronounced long-term care orientation. Federal Medicaid legislation does not limit the length of stay of a recipient in a nursing home. Additionally, by law, States are allowed to cover ICF's, but Medicare does not. In 1983, 43.5 percent of Medicaid program expenditures were for long-term care services.

Table 1.1

Medicare benefit payments and Medicaid assistance payments: Fiscal years 1983–88

Fiscal year	Total	Medicare benefit payments	Medicaid assistance payments
		Amount in billions	
1983	$88.0	$55.6	$32.4
1984	94.8	60.9	33.9
1985	107.1	69.6	37.5
1986	116.7	74.0	42.6
1987	121.6	76.2	45.4
1988	132.3	84.6	47.8
		Percent	
ACRG[1]	8.5	8.8	8.1

[1] Annual compound rate of growth.

SOURCES: 1983–85 data: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates. 1986–88 data: Office of Management and Budget estimates assuming current law.

Medicare and Medicaid expenditures

In Table 1.1 are shown Office of Management and Budget (OMB) estimates, assuming current law, of total program payments—Medicare benefit payments and Medicaid assistance payments—for fiscal years 1983–88. OMB estimated that payments for Medicare and Medicaid combined will increase from $88 billion in fiscal year 1983 to $132 billion in fiscal year 1988. In fiscal year 1988, Medicare benefit payments may total $85 billion and Medicaid assistance payments may reach $48 billion. The average annual rate of change, according to OMB, may be an increase of 8.8 percent for Medicare payments and 8.1 percent for Medicaid payments.

In Table 1.2 are Office of the Actuary (OACT) preliminary estimates of Medicare and Medicaid payments by type of service. OACT estimated that Medicare trust fund benefit payments increased 12.1 percent from calendar year 1984 to calendar year 1985. The largest payments were for inpatient hospital services. The 9.3-percent increase in Medicare inpatient hospital payments from 1984 to 1985 was the smallest rate of increase of any service shown in Table 1.2. The relatively low rate of increase was probably the result of the Medicare prospective payment system. Next in size were payments for physicians' services, which rose 12.2 percent, followed by payments for outpatient services, which increased 25 percent. OACT estimated that Medicaid payments rose 10.7 percent from fiscal year 1984 to fiscal year 1985. The largest payments were for ICF services, which increased 11.6 percent. Next in size were payments for inpatient hospital services, up 7.6 percent, followed by skilled nursing facility payments, up 5.5 percent.

Table 1.2

Medicare benefit payments in calendar years 1984–85 and Medicaid payments in fiscal years 1984–85, by type of service

Service	Medicare benefit payments			Medicaid payments		
	Amount in millions		Percent change	Amount in millions		Percent change
	1984	1985	1984–85	1984	1985	1984–85
All services	$62,918	$70,527	12.1	$33,891	$37,508	10.7
Inpatient hospital	40,733	44,517	9.3	9,890	10,645	7.6
Physicians'	15,434	17,312	12.2	2,220	2,346	5.7
Outpatient	3,449	4,311	25.0	1,646	1,789	8.7
Skilled nursing facility	532	603	13.3	4,810	5,073	5.5
Intermediate care facility (ICF)	NA	NA	NA	10,079	11,245	11.6
ICF/MR[1]	NA	NA	NA	4,256	4,719	10.9
ICF, all other	NA	NA	NA	5,823	6,526	12.1
Home health agency	1,971	2,349	19.2	774	1,120	44.7
Group practice plan	464	720	55.2	—	—	—
Prescribed drugs	NA	NA	NA	1,968	2,315	17.6
Other[2]	335	715	113.4	2,504	2,975	18.8

[1] Intermediate care facility for the mentally retarded.
[2] For Medicare: independent laboratory, peer review organization, and hospice services. For Medicaid: dental, other practitioners', laboratory and radiological, family planning, clinic, early periodic screening, and other care services.

NOTE: Data are preliminary.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

Table 1.3

Medicare enrollees, persons served, and reimbursements in calendar year 1982 and Medicaid recipients and payments in fiscal year 1983, by area

Area[1]	Medicare		Medicaid recipients in thousands	Medicare reimbursements in millions	Medicaid payments in millions	Medicare reimbursement per person served	Medicaid payment per recipient
	Enrollees in thousands[2]	Persons served in thousands					
All areas	29,494.6	18,821.9	21,492.5	$47,698.2	$32,350.5	$2,534	$1,505
United States	28,885.6	18,702.3	19,934.3	47,533.4	32,228.2	2,542	1,617
Alabama	508.9	314.2	311.3	760.2	368.7	2,419	1,184
Alaska	14.4	9.1	20.0	27.1	51.2	2,964	2,558
Arizona[3]	356.9	236.2	NA	554.7	NA	2,348	NA
Arkansas	355.9	217.2	190.3	456.1	313.2	2,100	1,646
California	2,734.6	1,926.2	3,499.9	5,576.6	3,557.2	2,895	1,016
Colorado	281.1	184.1	147.6	440.6	255.3	2,394	1,729
Connecticut	411.4	283.6	215.5	644.4	495.4	2,272	2,299
Delaware	70.2	47.3	45.6	105.8	62.1	2,237	1,361
District of Columbia	77.4	53.1	117.7	204.5	196.5	3,849	1,670
Florida	1,830.1	1,290.5	555.2	3,258.5	681.3	2,525	1,227
Georgia	613.6	387.9	441.1	823.8	601.4	2,124	1,363
Hawaii	89.1	57.7	100.3	142.1	141.7	2,464	1,413
Idaho	109.6	68.2	39.2	135.5	67.3	1,986	1,715
Illinois	1,387.5	818.7	1,051.0	2,601.6	1,347.0	3,178	1,282
Indiana	665.2	396.5	271.7	1,009.0	596.0	2,545	2,194
Iowa	424.8	260.1	189.5	580.6	312.0	2,232	1,647
Kansas	332.8	222.1	147.2	550.7	254.5	2,479	1,729
Kentucky	476.6	260.7	388.0	615.6	411.0	2,361	1,059
Louisiana	453.3	249.7	378.0	634.6	674.7	2,541	1,785
Maine	162.7	109.2	122.2	243.0	205.1	2,226	1,679
Maryland	445.1	296.1	328.0	867.8	446.6	2,931	1,362
Massachusetts	797.2	554.9	579.1	1,528.6	1,338.2	2,755	2,311
Michigan	1,072.0	761.9	1,187.6	2,137.0	1,421.7	2,805	1,197
Minnesota	528.9	328.1	326.4	736.5	868.1	2,245	2,660
Mississippi	333.7	200.1	290.5	430.0	299.4	2,149	1,031
Missouri	719.4	432.5	341.6	1,180.8	468.5	2,730	1,371
Montana	98.8	60.7	44.8	132.7	86.2	2,185	1,925
Nebraska	223.1	128.5	84.0	293.3	146.0	2,283	1,738
Nevada	82.7	53.3	27.9	176.8	73.7	3,317	2,644
New Hampshire	117.4	77.0	41.7	171.4	93.1	2,227	2,231

See footnotes at end of table.

Table 1.3—Continued

Medicare enrollees, persons served, and reimbursements in calendar year 1982 and Medicaid recipients and payments in fiscal year 1983, by area

Area[1]	Medicare		Medicaid	Medicare	Medicaid	Medicare	Medicaid
	Enrollees in thousands[2]	Persons served in thousands	recipients in thousands	reimbursements in millions	payments in millions	reimbursement per person served	payment per recipient
New Jersey	976.3	671.9	611.9	$1,681.9	$981.5	$2,503	$1,604
New Mexico	137.6	84.5	84.4	181.1	101.8	2,144	1,206
New York	2,386.5	1,675.4	2,160.6	4,033.6	6,259.5	2,408	2,897
North Carolina	716.8	421.9	349.1	892.4	567.0	2,115	1,624
North Dakota	90.0	59.4	31.9	146.9	83.3	2,473	2,610
Ohio	1,344.7	845.1	910.6	2,258.2	1,474.3	2,672	1,619
Oklahoma	408.8	243.0	232.5	571.7	388.7	2,353	1,672
Oregon	347.2	217.5	153.8	528.0	236.2	2,428	1,536
Pennsylvania	1,738.5	1,156.5	1,167.2	3,083.8	1,718.8	2,667	1,473
Rhode Island	142.9	108.4	104.6	223.3	221.7	2,060	2,119
South Carolina	349.7	204.1	236.2	430.5	278.8	2,110	1,180
South Dakota	100.7	58.3	33.5	133.1	77.8	2,284	2,322
Tennessee	598.8	350.6	341.2	811.5	508.6	2,315	1,490
Texas	1,509.9	928.3	680.1	2,395.7	1,316.7	2,581	1,936
Utah	125.4	74.9	66.0	150.8	114.5	2,011	1,734
Vermont	66.9	45.2	53.6	95.8	84.3	2,119	1,572
Virginia	587.9	364.6	306.4	837.9	488.2	2,298	1,593
Washington	493.5	327.4	257.6	663.8	427.1	2,027	1,658
West Virginia	282.1	160.8	177.4	373.2	140.6	2,321	793
Wisconsin	638.2	393.9	480.1	952.9	901.1	2,419	1,877
Wyoming	42.5	24.1	14.2	60.6	24.4	2,512	1,721
State unknown	26.3	1.2	NA	6.6	NA	5,541	NA
U.S. territories and possessions[4]	379.0	113.8	1,558.2	149.0	122.4	1,310	79
Guam	2.4	0.5	—	1.7	—	3,354	—
Puerto Rico	370.3	111.1	1,547.1	143.1	119.8	1,288	77
Virgin Islands	5.3	1.9	11.1	3.6	2.6	1,864	230
Foreign countries	230.0	5.9	NA	15.8	NA	2,698	NA

[1] For Medicare, area of enrollee; for Medicaid, area of provider of medical services.
[2] As of July 1, 1982.
[3] Arizona does not have a Medicaid program.
[4] Includes all other outlying areas.

NOTE: Medicare data are for services rendered during calendar year 1982; Medicaid data are for services paid for during fiscal year 1983.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Medicare and Medicaid population and expenditures

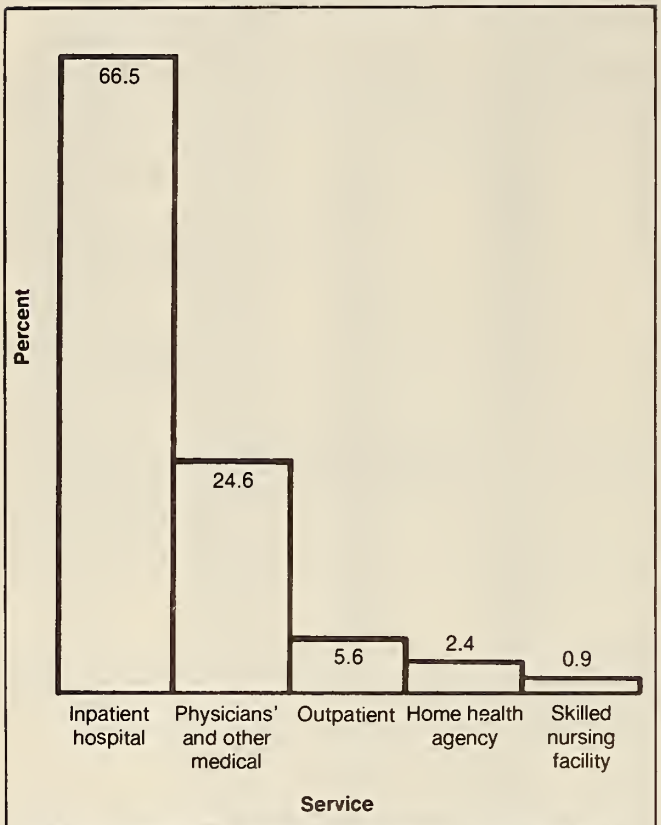
In Table 1.3, Medicare and Medicaid population data and expenditures are compared. In calendar year 1982, 18.8 million (63.8 percent) of the 29.5 million aged and disabled persons enrolled in Medicare received Medicare reimbursements. In fiscal year 1983, 21.5 million persons received health services paid for by Medicaid. Twenty-six percent of all persons served under the Medicare program resided in California, New York, or Florida. For Medicaid, the three States with the largest number of recipients in fiscal year 1983 were California, New York, and Michigan, which together accounted for 32 percent of all Medicaid recipients.

In calendar year 1982, Medicare spent $47.7 billion; in fiscal year 1983, $32.4 billion were spent on behalf of Medicaid recipients. Medicare reimbursements in calendar year 1982 were largest for California residents ($5.6 billion). Reimbursements for residents of New York ($4.0 billion), Florida ($3.3 billion), and Pennsylvania ($3.1 billion) were next in size. Together, these four States accounted for 33 percent of total Medicare reimbursements. Payments for Medicaid recipients in fiscal year 1983 were largest in New York ($6.3 billion), California ($3.6 billion), Pennsylvania ($1.7 billion), Ohio ($1.5 billion), and Michigan ($1.4 billion). These five States accounted for 45 percent of total Medicaid expenditures.

The average Medicare reimbursement per person served was $2,534 in calendar year 1982. The average payment per Medicaid recipient was $1,505 in fiscal year 1983. Medicare enrollees in the District of Columbia had the largest reimbursement per person served ($3,849), with total reimbursements of $205 million. Next in size were Nevada ($3,317), with total reimbursements of $177 million, and Illinois ($3,178), with total reimbursements of $2,602 million. Payments per Medicaid recipient in fiscal year 1983 were highest in New York ($2,897), with total payments of $6,259.5 million; Minnesota ($2,660), with total payments of

Figure 1.1

Percent distribution of Medicare reimbursements, by type of service: Calendar year 1982



SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982*. HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

$868.1 million; and Nevada ($2,644), with total payments of $73.7 million.

Several important differences between Medicare and Medicaid are illustrated in Figures 1.1 through 1.3. As shown in Figure 1.1, Medicare is oriented toward acute care services, consistent with its statute. Inpatient hospital care accounts for two-thirds of total Medicare reimbursements (HI and SMI combined). Less than 1 percent of Medicare reimbursements go to SNF's, with coverage limited to short-term posthospital recuperative or rehabilitative care. In contrast, as shown in Figure 1.2, inpatient hospital services absorb only 30.1 percent of total Medicaid payments, with payments for long-term care in nursing homes, both ICF's and SNF's, making up 43.5 percent of the total Medicaid payments.

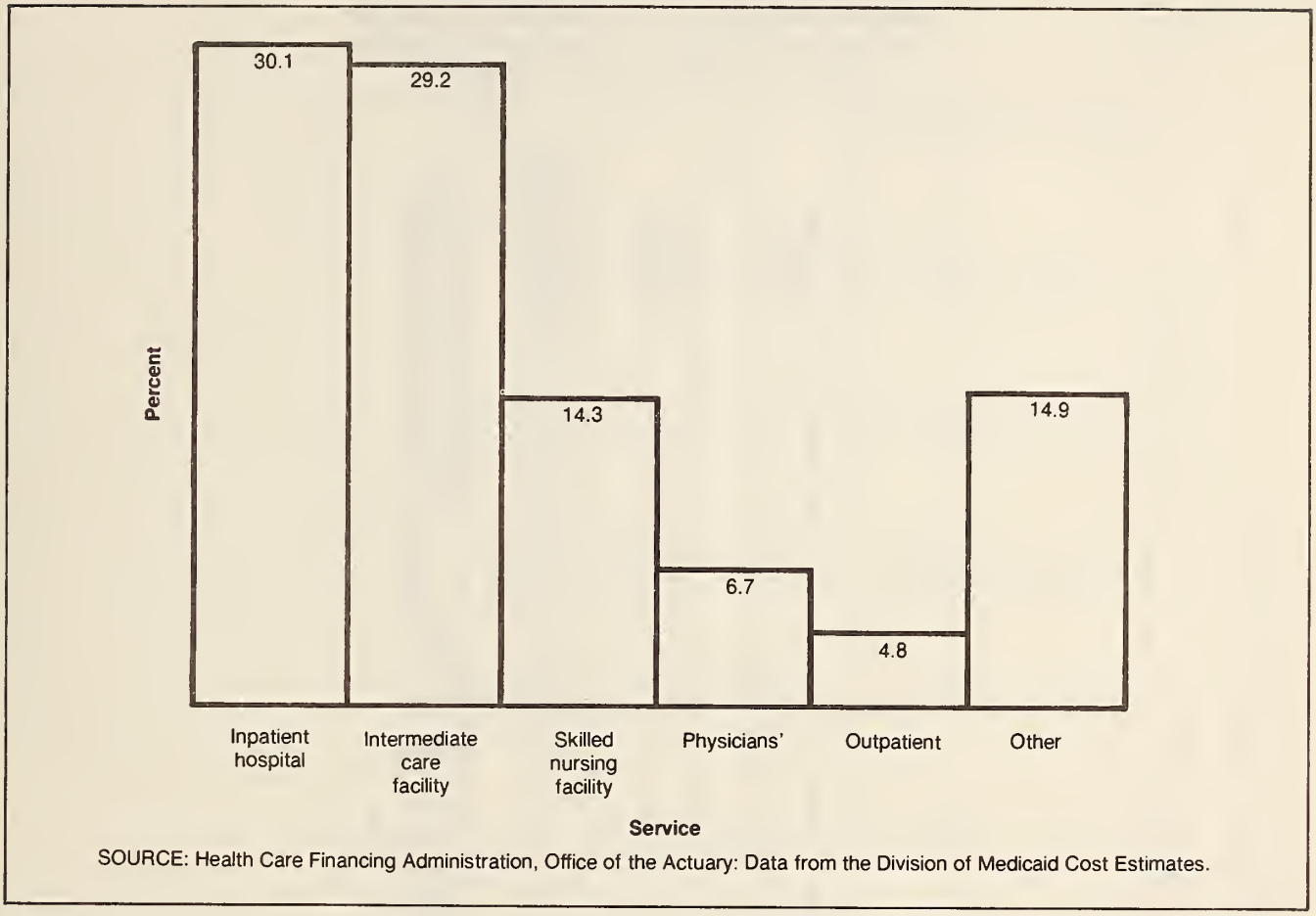
Medicare and Medicaid also differ in the relative size and distribution of reimbursements among their enrollee and eligibility groups. As shown in Figure 1.3, Medicare serves predominantly the aged, who comprise 90 percent of all enrollees and receive 87 percent of all reimbursements. Medicaid aged and disabled make up 29 percent of all recipients but are responsible for 72 percent of all payments. In contrast, children and adults eligible through the Aid to Families with Dependent Children category make up 69 percent of all Medicaid recipients but account for only 26 percent of total payments.

Personal health care costs for the aged

In Table 1.4, national health care costs of the aged in calendar year 1984 are shown by source of funds. Government programs paid two-thirds of all personal health care costs for the aged and nearly 90 percent of hospital expenditures. Medicare paid for 75 percent of

Figure 1.2

Percent distribution of Medicaid payments, by type of service: Fiscal year 1983



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

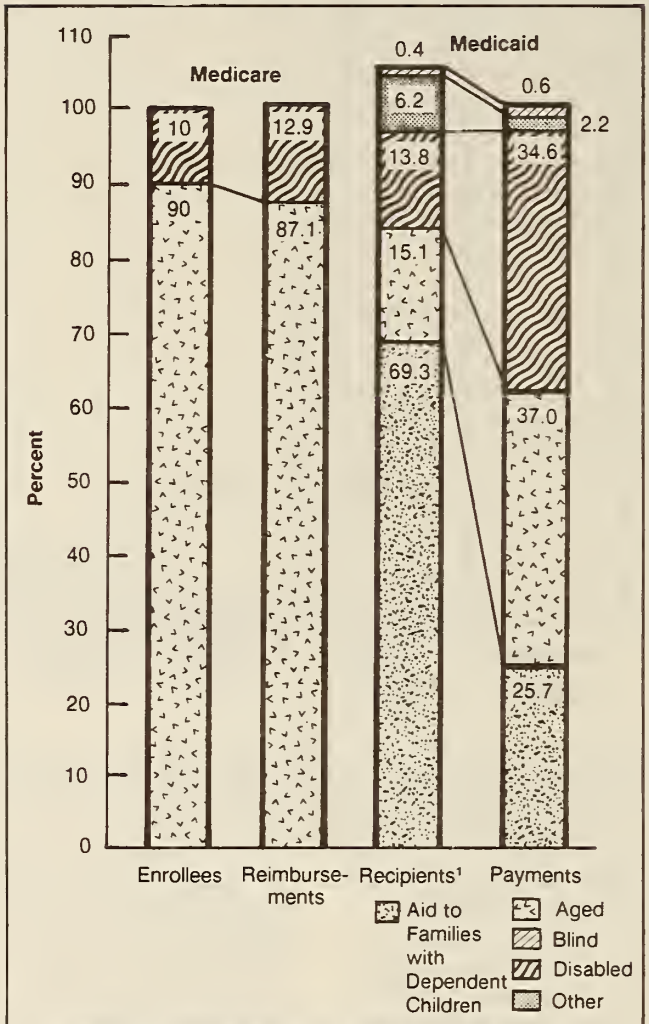
hospital costs and 58 percent of physician care. Medicaid was the most important payer of public health programs for nursing home care, covering 42 percent. Of the nearly one-third of personal health care expenditures paid for by the aged consumer of services, one-quarter was paid out of pocket and 7 percent was from private health insurance.

Program administration

Medicare and Medicaid were administered by separate agencies in the Department of Health, Education, and Welfare from 1965 to 1977. In 1977, these agencies were merged into the Health Care Financing Administration within the Department of Health and Human Services. Under the new structure, the operation of Medicare and Medicaid is combined, with each newly created bureau or office dealing with a specific aspect of both programs. These changes were designed to reduce duplication of effort and enhance consistency and coordination of Medicare and Medicaid. An intermediate level of associate administrators was added in 1981. Starting in 1986, the Associate Administrator for External Affairs and the four staff offices shown in Figure 1.4 report to the Administrator. The three other associate administrators report to the Executive Associate Administrator.

Figure 1.3

Percent distributions of Medicare enrollees and reimbursements, by type of enrollee, in calendar year 1982 and Medicaid recipients and payments, by basis of eligibility, in fiscal year 1983



[1] The sum of percentages by basis of eligibility exceed 100 percent because as a recipient may be counted in more than one eligibility group.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982*. HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 1.4

Personal health care expenditures for persons 65 years of age or over, by type of service and source of funds: United States, calendar year 1984

Source of funds	All services	Hospital	Physicians'	Nursing home [1]	Other services	All services	Hospital	Physicians'	Nursing home	Other services
	Amount in millions					Percent distribution of amount				
Total	$119,872	$54,200	$24,770	$25,105	$15,798	100.0	100.0	100.0	100.0	100.0
Private	39,341	6,160	9,827	13,038	10,316	32.8	11.4	39.7	51.9	65.3
Consumer	38,875	5,964	9,818	12,856	10,237	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	30,198	1,694	6,468	12,569	9,467	25.2	3.1	26.1	50.1	59.9
Insurance	8,677	4,270	3,350	287	770	7.2	7.9	13.5	1.1	4.9
Other private	466	196	9	182	79	0.4	0.4	—	0.7	0.5
Government	80,531	48,040	14,943	12,067	5,482	67.2	88.6	60.3	48.1	34.7
Medicare	58,519	40,524	14,314	539	3,142	48.8	74.8	57.8	2.1	19.9
Medicaid	15,288	2,595	467	10,418	1,808	12.8	4.8	1.9	41.5	11.4
Other government [2]	6,724	4,920	162	1,110	532	5.6	9.1	0.7	4.4	3.4
	Per capita amount					Percent distribution of per capita amount				
Total	$4,202	$1,900	$868	$880	$554	100.0	45.2	20.7	20.9	13.2
Private	1,379	216	344	457	362	100.0	15.7	25.0	33.1	26.2
Consumer	1,363	209	344	451	359	100.0	15.3	25.3	33.1	26.3
Out-of-pocket	1,059	59	227	441	332	100.0	5.6	21.4	41.6	31.3
Insurance	304	150	117	10	27	100.0	49.2	38.6	3.3	8.9
Other private	16	7	1	6	3	100.0	42.1	1.9	39.1	17.0
Government	2,823	1,684	524	423	192	100.0	59.7	18.6	15.0	6.8
Medicare	2,051	1,420	502	19	110	100.0	69.2	24.5	0.9	5.4
Medicaid	536	91	16	365	63	100.0	17.0	3.1	68.1	11.8
Other government [2]	236	172	6	39	19	100.0	73.2	2.4	16.5	7.9

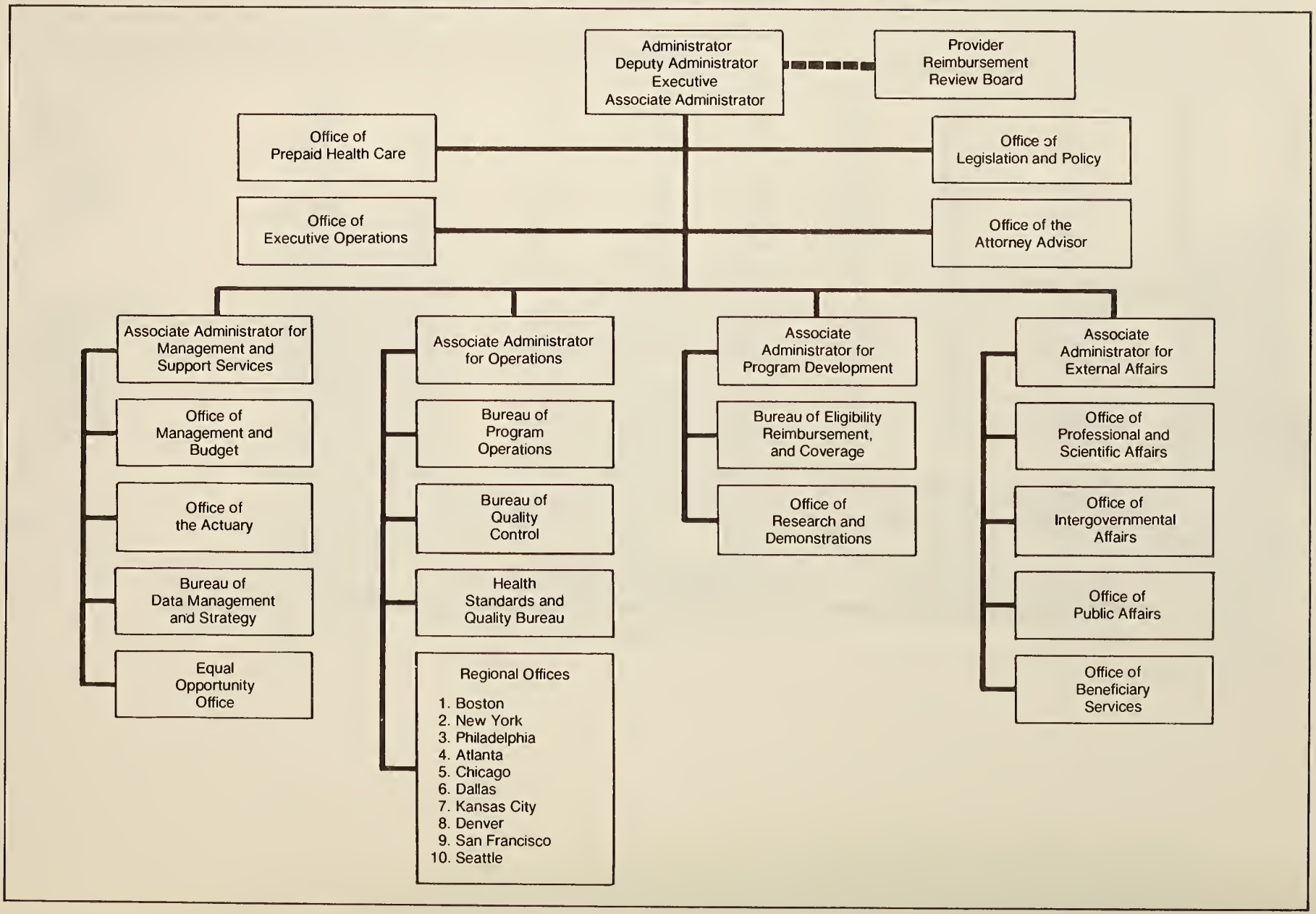
[1] Nursing home care includes services provided in all facilities that are Medicare- or Medicaid-certified skilled nursing facilities, Medicaid-certified intermediate care facilities, or any other home providing some level of nursing care, whether certified by either program or not. Facilities that provide only domiciliary care are excluded.

[2] Includes expenditures for health care by the Veterans' Administration, the Department of Defense, workers' compensation programs, State and local governments (except for Medicaid expenditures), and Federal medical public assistance programs other than Medicare and Medicaid.

SOURCE: Waldo, D. R., and Lazenby, H. C.: Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984. *Health Care Financing Review.* Vol. 6, No. 1. HCFA Pub. No. 03176. Office of Research and Demonstrations, Health Care Financing Administration. Washington. U.S. Government Printing Office, Fall 1984.

Figure 1.4

Health Care Financing Administration organizational chart: June 1986



2. Medicare and Medicaid trends

In this chapter, trends in the Medicare and Medicaid programs are reported: the number of Medicare enrollees and Medicaid recipients by basis of eligibility and population characteristics; expenditures, in total and by eligibility category; and hospital inpatient services, physicians' services, and other services financed by the Medicare and Medicaid programs. A time series of Medicare deductibles and coinsurance amounts is presented. A discussion of Medicare and Medicaid issues concludes the chapter.

Enrollees and recipients

As shown in Table 2.1, the number of Medicare enrollees increased 2.7 percent per year from 1966 through 1982. (The annual compound rate of growth, ACRG, is expressed as a percent in the tables.) Supplementary medical insurance (SMI) enrollment increased slightly faster than hospital insurance (HI) enrollment. Total enrollment jumped 10 percent from 1972 to 1973, reflecting the extension of Medicare coverage to the disabled by the 1972 Amendments to the Social Security Act. Prior to the 1972 amendments, only persons 65 years of age or over were covered by Medicare.

From fiscal year 1973 to fiscal year 1983, the number of Medicaid recipients (persons who received services paid for by Medicaid) increased 0.9 percent a year.[3] This upward trend included periods of growth and decline (Figure 2.1). The number of Medicaid recipients increased through 1977, then declined through 1979, rose slightly from 1980 to 1981, and declined again until 1983. In contrast, Medicare enrollment grew continuously from 1966 to 1982.

Medicare enrollees

Table 2.2 contains data on the number of aged HI and SMI enrollees by age, sex, and race for calendar years 1966 through 1982. All demographic groups in the table grew in size, with SMI enrollment increasing faster than HI enrollment in each group. For both HI and SMI, enrollment increases were smaller for men than women, for white persons than all other persons, and for the younger age group (65–74) than persons 75 years of age or over. The gradual aging of Medicare enrollees has long-term consequences for the Medicare program because older enrollees are relatively high users of health care services and raise the reimbursement per enrollee.

[3] The Medicaid data presented in this report were first compiled in the present format in fiscal year 1973. Previous data were based on reporting categories different from those now used. To avoid erroneous inferences, the data for earlier years are excluded from this report.

Table 2.1

Number of Medicare enrollees by type of coverage and number of Medicaid recipients: 1966–83

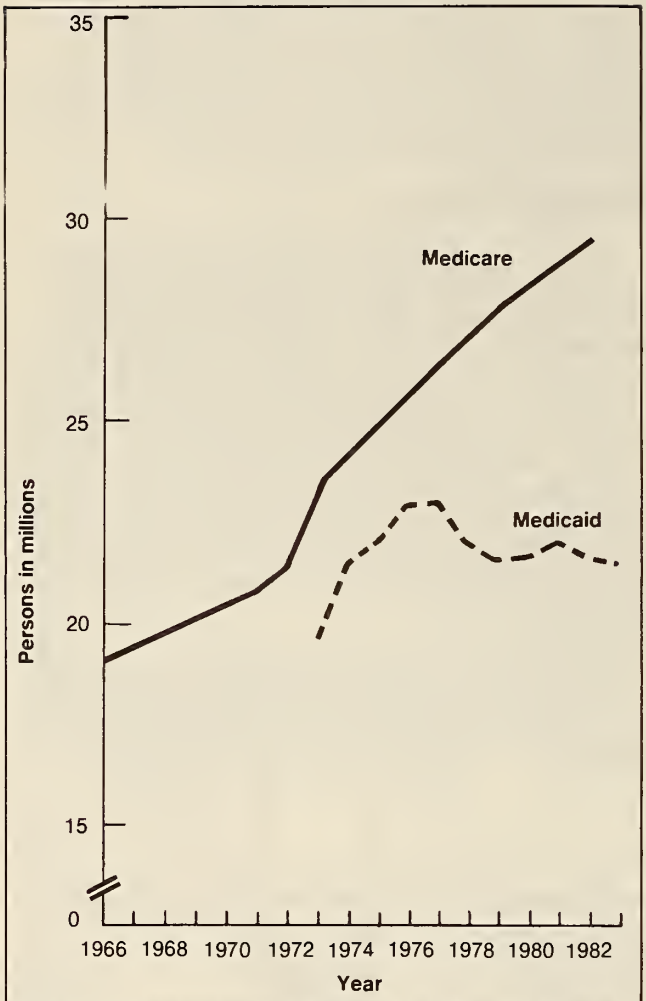
Year[1]	Medicare enrollees			Medicaid recipients
	Hospital insurance and/or supplementary medical insurance	Hospital insurance	Supplementary medical insurance	
	Number in thousands			
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914.9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,462.0
1975	24,958.6	24,640.5	23,904.6	22,006.6
1976	25,662.9	25,312.6	24,614.4	22,814.6
1977	26,457.9	26,093.9	25,363.5	22,831.8
1978	27,164.2	26,777.3	26,074.1	21,964.8
1979	27,858.7	27,459.2	26,757.3	21,520.5
1980	28,478.2	28,066.9	27,399.7	21,604.6
1981	29,010.0	28,589.5	27,941.2	21,979.6
1982	29,494.2	29,069.0	28,412.3	21,603.2
1983	—	—	—	21,492.5
	Percent			
ACRG[2]	2.7	2.7	3.0	0.9

[1] Medicare data are for July 1 of each calendar year; Medicaid data are for each fiscal year.
[2] Annual compound rate of growth.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.1

Number of Medicare enrollees and Medicaid recipients: 1966–83



SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics*, 1982. HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

The rate of growth in the number of disabled enrollees (Table 2.3) was much greater than that of aged enrollees (Table 2.2). For both HI and SMI, the greatest increase in enrollment among the disabled occurred in the youngest age group, under 35 years. HI and SMI enrollment showed smaller increases for males than females and for white enrollees than all others. Both HI and SMI enrollment of the disabled fell from 1981 to 1982, the first decline since the disabled were covered by Medicare.

Medicaid recipients

Trend data on the number of Medicaid recipients by basis of eligibility and maintenance assistance status are presented in Table 2.4. Recipients are divided into two groups: those who receive cash payments as well as Medicaid benefits and those who receive medical assistance only.[4]

From fiscal year 1973 to fiscal year 1983, the total number of cash assistance recipients using Medicaid services increased at an average rate of 1.2 percent a year. The number of Medicaid recipients in the aged and blind cash assistance groups decreased during the same period at annual rates of 2.2 and 2.3 percent per year, respectively. Of all cash assistance groups, the highest rate of growth in the number of Medicaid recipients occurred among disabled enrollees. Most of this increase occurred from 1973 to 1977, when the total number of disabled cash recipients increased by more than one-half. The number of children under age 21, who comprise 49 percent of all cash assistance Medicaid recipients, grew at an annual rate of 1.3 percent per year.

The number of Medicaid recipients not receiving cash assistance increased at a slightly faster rate than the cash assistance group, 1.7 percent per year. Among recipients of medical assistance only, the number of disabled recipients and adult recipients covered under the Aid to Families with Dependent Children (AFDC) program grew most rapidly, at rates of 7.1 and 9.0 percent per year, respectively. The number of children under 21 years of age who received "medical assistance only" services decreased by an annual compound rate of growth of 1.3 percent.

Data for fiscal years 1973–83 on the age, sex, and race of Medicaid recipients are presented in Table 2.5. The Office of Actuary estimated the race of a large number of recipients for States not reporting race. Therefore, Medicaid data by race in this report should be used with caution. The number of recipients in the group 65 years of age or over decreased at an annual rate of 1.3 percent. The number in all other age groups grew at rates ranging from 0.6 to 2.4 percent per year.

[4] Data on medically needy recipients, a subgroup of recipients receiving medical assistance only, is available on request for fiscal year 1975 and later years from the Office of the Actuary.

Table 2.2

Number of aged Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1966–82

Year	Hospital insurance							Supplementary medical insurance						
		Age		Sex		Race[1]			Age		Sex		Race[1]	
	Total	65–74 years	75 years or over	Male	Female	White	All other	Total	65–74 years	75 years or over	Male	Female	White	All other
	Number in thousands													
1966	19,082	11,990	7,092	8,133	10,950	17,042	1,445	17,736	11,186	6,550	7,534	10,202	15,938	1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	1,496	17,893	11,114	6,779	7,547	10,346	16,124	1,245
1968	19,770	12,158	7,611	8,318	11,452	17,632	1,525	18,805	11,561	7,244	7,878	10,927	16,877	1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	1,558	19,195	11,705	7,490	8,010	11,185	17,229	1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	1,608	19,584	11,873	7,711	8,132	11,452	17,576	1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	1,672	19,975	12,050	7,924	8,250	11,724	17,974	1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	1,693	20,351	12,248	8,104	8,360	11,991	18,325	1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	1,762	20,921	12,586	8,334	8,569	12,352	18,737	1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	1,809	21,422	12,925	8,496	8,694	12,727	19,149	1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	1,870	21,945	13,215	8,730	8,873	13,073	19,575	1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	1,916	22,446	13,529	8,917	9,047	13,399	19,995	1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	1,977	22,991	13,830	9,161	9,240	13,751	20,456	1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	2,036	23,531	14,119	9,412	9,436	14,094	20,904	1,978
1979	24,584	14,582	9,967	9,945	14,604	21,770	2,100	24,098	14,414	9,685	9,645	14,454	21,385	2,046
1980	25,104	14,894	10,210	10,156	14,948	22,244	2,160	24,680	14,726	9,954	9,868	14,813	21,876	2,114
1981	25,591	15,152	10,439	10,340	15,250	22,661	2,210	25,182	14,977	10,205	10,055	15,127	22,298	2,172
1982	26,115	15,386	10,728	10,538	15,577	23,104	2,265	25,707	15,192	10,515	10,250	15,457	22,738	2,231
	Percent													
ACRG[2]	2.0	1.6	2.6	1.6	2.2	1.9	2.8	2.3	1.9	3.0	1.9	2.6	2.2	3.6

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

Expenditures

Data on Medicare benefit payments from the trust funds and Medicaid payments are shown in Table 2.6 and Figure 2.2. Total Medicare benefit payments grew at an average annual rate of 17.5 percent from 1967 to 1982. SMI benefit payments increased more rapidly than HI benefit payments. The large increase in total benefit payments from 1973 to 1974, 29.6 percent, reflects the extension of Medicare coverage to the disabled. The entry of the disabled also accelerated the rate of increase in SMI benefit payments, largely because of the rising number of end stage renal disease (ESRD) patients with SMI coverage. As explained in detail in the section on services to ESRD enrollees, charges for renal dialysis have generally been held to a $138 maximum per treatment ($110 in reimbursements). Thus, the accelerating rate of SMI reimbursements among the disabled reflects increases in the number of ESRD patients rather than increases in reimbursements per patient. Because ESRD users generally require three treatments a week, a regular schedule of dialysis at $138 per treatment costs about $22,000 a year for the average user ($17,000 in reimbursements).

Medicaid payments also increased, growing at an average annual rate of 14.1 percent from fiscal year 1973 to fiscal year 1983. Payments for the aged, blind, and disabled grew the fastest. As indicated in Figure 2.2, annual percentage increases in Medicare reimbursements have been higher historically than those for Medicaid payments.

Changes over time in the distribution of Medicare reimbursements and Medicaid payments by type of service covered are shown in Figures 2.3 and 2.4. The proportion of total Medicaid payments for inpatient hospital (general and mental hospital) services decreased from 30.8 percent in 1973 to 30.1 percent in 1983. Conversely, the proportion of Medicare reimbursements for inpatient hospital services increased slightly, from 62.7 percent in 1967 to 66.5 percent in 1982. Over the same period, a small decrease (from 28.9 percent in 1967 to 24.6 percent in 1982) occurred in the proportion of all Medicare reimbursements made for physicians' and other medical services. Physician payments as a proportion of total Medicaid payments also decreased, from 10.7 percent in 1973 to 6.7 percent in 1983.

Reimbursements for outpatient services as a proportion of all Medicare reimbursements increased sixfold from 1967 to 1982, from 0.9 percent to 5.6 percent. In part, this increase reflects use of renal dialyses by ESRD patients. Medicaid payments for outpatient services increased at a much slower rate, from 3.1 percent in 1973 to 4.8 percent in 1983. For home health agency services, Medicare reimbursements increased from 1.0 percent to 2.4 percent from 1967 to 1982. The proportion of Medicare reimbursements for skilled nursing facility services decreased markedly from 1967 (6.5 percent) to 1982 (0.9 percent). In contrast, Medicaid payments for nursing home care increased from 34.9 percent in 1973 to 43.5 percent in 1983. As these charts show, long-term care services account for the largest proportion of total Medicaid payments, but Medicare is an acute care program.

Table 2.3

Number of disabled Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1973–82

Year	Hospital insurance									Supplementary medical insurance								
		Age				Sex		Race[1]			Age				Sex		Race[1]	
	Total	Under 35 years	35–44 years	45–54 years	55–64 years	Male	Female	White	All other	Total	Under 35 years	35–44 years	45–54 years	55–64 years	Male	Female	White	All other
	Number in thousands																	
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	253.2	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	233.4
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	287.1	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	263.1
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	329.2	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	300.3
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	370.9	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	339.6
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	415.1	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	379.3
1978	2,793.2	344.8	335.4	646.5	1,466.5	1,763.0	1,030.2	2,299.1	447.8	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	411.0
1979	2,910.8	361.4	356.0	658.0	1,535.3	1,837.4	1,073.4	2,388.1	471.4	2,658.8	328.6	323.4	592.6	1,414.3	1,655.1	1,003.7	2,176.7	433.9
1980	2,963.2	371.2	369.5	657.5	1,565.0	1,870.5	1,092.6	2,422.2	486.7	2,719.2	339.7	337.1	596.3	1,446.1	1,694.6	1,024.7	2,218.2	449.8
1981	2,999.0	383.5	385.1	654.7	1,575.6	1,896.0	1,102.9	2,442.1	499.9	2,759.5	352.7	352.3	596.3	1,458.2	1,723.9	1,035.6	2,242.3	463.5
1982	2,954.2	377.7	386.0	622.2	1,568.4	1,865.2	1,089.0	2,399.6	497.3	2,705.5	345.8	347.4	561.1	1,451.2	1,687.6	1,017.9	2,192.7	458.7
	Percent																	
ACRG[2]	6.1	7.8	6.6	4.0	6.6	5.8	6.6	5.8	7.8	6.2	7.9	6.6	4.1	6.7	5.9	6.7	5.9	7.8

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

Table 2.4

Number of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal years 1973–83

Year	Cash assistance							Medical assistance only						
		SSI[1]			AFDC[2]				SSI[1]			AFDC[2]		
	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX[4]	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX
	Number in thousands													
1973	14,519.9	2,226.9	83.6	1,425.4	7,017.3	3,616.7	150.0	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2
1974	15,969.1	2,510.3	99.9	1,810.8	7,693.9	3,727.8	126.3	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9
1975	16,678.0	2,416.2	84.6	1,865.8	8,349.3	3,962.1	NA	5,328.6	1,199.1	24.7	489.1	1,248.9	567.0	1,799.9
1976	17,221.9	2,396.7	78.5	2,037.7	8,527.0	4,182.0	NA	5,592.7	1,215.5	18.4	534.5	1,396.6	591.3	1,836.4
1977	17,066.9	2,367.7	76.0	2,172.0	8,359.0	4,091.6	NA	5,764.9	1,267.9	16.3	537.9	1,291.1	693.3	1,958.5
1978	16,423.0	2,133.4	67.2	2,081.9	8,165.3	3,975.2	NA	5,541.8	1,242.4	14.6	554.0	1,210.3	668.0	1,852.5
1979	16,055.9	2,092.5	67.5	2,088.6	7,905.9	3,901.4	NA	5,464.6	1,271.8	11.7	585.1	1,200.5	668.2	1,727.3
1980	16,506.0	2,035.3	76.7	2,186.4	8,114.2	4,093.5	NA	5,553.5	1,404.8	14.9	632.5	1,219.0	783.2	1,499.1
1981	16,911.9	1,952.6	71.1	2,254.9	8,305.9	4,327.5	NA	5,665.9	1,414.0	15.3	737.8	1,274.8	859.7	1,364.3
1982	16,671.1	1,850.7	72.7	2,190.6	8,187.0	4,370.1	NA	5,812.6	1,389.0	11.6	615.7	1,376.5	986.2	1,433.7
1983	16,435.3	1,780.2	66.2	2,205.6	7,980.5	4,402.8	NA	6,052.7	1,466.0	10.0	749.5	1,437.8	1,064.0	1,325.3
	Percent													
ACRG[5]	1.2	−2.2	−2.3	4.5	1.3	2.0	NA	1.7	1.5	−5.5	7.1	−1.3	9.0	−0.2

[1] Supplemental Security Income.
[2] Aid to Families with Dependent Children.
[3] Totals for each year include estimated recipient counts for nonreporting States. The sum of recipients in the maintenance assistance categories exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.
[4] Cash assistance to other Title XIX recipients was phased out after 1974.
[5] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.5

Number of Medicaid recipients, by age, sex, and race: Fiscal years 1973–83

Year	Total	Age				Sex		Race		
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	All other	Unknown
	Number in thousands									
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,462.0	3,466.1	6,827.0	7,423.7	3,745.1	7,462.4	13,999.6	—	—	—
1975	22,006.6	3,334.0	7,257.7	7,660.5	3,754.3	7,686.9	14,319.7	8,234.6	6,105.9	7,666.0
1976	22,814.6	3,584.2	7,706.7	7,843.7	3,680.0	7,973.7	14,840.9	8,355.4	6,598.2	7,861.0
1977	22,831.8	3,490.9	7,331.3	8,235.4	3,774.1	8,034.5	14,797.3	8,439.1	6,396.5	7,996.2
1978	21,964.8	3,402.4	7,165.0	7,874.3	3,523.1	7,639.3	14,325.5	8,121.5	6,247.0	7,596.3
1979	21,520.5	3,398.1	6,850.0	7,504.2	3,768.3	7,467.6	14,052.9	8,036.2	7,119.4	6,364.8
1980	21,604.6	4,017.5	6,906.4	7,350.1	3,330.5	7,702.4	13,902.2	7,846.7	6,275.9	7,481.8
1981	21,979.6	4,087.2	7,026.3	7,477.7	3,388.3	7,836.1	14,143.5	7,982.9	6,384.8	7,611.7
1982	21,603.2	3,996.6	6,848.2	6,999.4	3,759.0	7,777.2	13,826.0	8,142.7	6,209.5	7,251.0
1983	21,492.5	4,449.0	6,340.2	6,770.1	3,933.2	7,715.8	13,776.7	11,992.3	9,500.2	0.0
	Percent									
ACRG[1]	0.9	2.4	0.6	0.7	−1.3	0.7	1.1	4.8	5.7	—

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Medicare reimbursements

Trend data on Medicare reimbursements based on claims paid in a calendar year are shown in Table 2.7 by type of coverage and type of enrollee. Successive increases in reimbursements for each entitlement group resulted in a ninefold increase in total reimbursements from 1968 to 1982. Some of this increase reflects, of course, the extension of Medicare coverage to disabled persons in 1973. As derived from Table 2.7, reimbursements for the disabled grew much faster than reimbursements for the aged, increasing to 13.2 percent of total reimbursements in 1982 from 8.7 percent in 1974.

As shown in Figure 2.5, a small proportion of enrollees with large medical expenses accounted for a large proportion of Medicare reimbursements for both aged and disabled enrollees. Enrollees reimbursed $15,000 or more represented only 1.9 percent of all

aged persons ever enrolled in 1982 but accounted for 31.3 percent of all Medicare reimbursements for the aged. At the other extreme, 39.3 percent of aged enrollees received no reimbursements during the year. (Reasons for no reimbursements are: not having covered Medicare charges, not exceeding Medicare deductibles, exceeding deductibles but not filing claims, or receiving covered services without charge.) Another 38.3 percent of aged enrollees received less than $1,000 in reimbursements.

An even more graphic example of how health insurance spreads the risk of illness is provided by comparable figures for the disabled. Although representing only 3.4 percent of all disabled enrollees, those in the group reimbursed $15,000 or more accounted for 48.1 percent of all Medicare reimbursements for disabled enrollees. "High-cost" users account for a larger share of reimbursements in the disabled group than in the aged group, partly because of the significantly greater proportion of ESRD patients among disabled enrollees. Also, 45.2 percent of the disabled received no reimbursement.

Medicaid payments

As shown in Table 2.8, Medicaid payments grew the fastest for services provided to the disabled in both maintenance assistance groups. The slowest rate of increase occurred for children under 21 years of age not receiving cash assistance. This contrasts sharply with the relatively rapid growth in payments for children receiving cash assistance. As shown in Table 2.4, the number of children receiving only medical assistance declined by 12 percent from fiscal year 1973 to fiscal year 1983.

Trends in Medicaid payments for long-term care, inpatient hospital services, and all other Medicaid services are shown in Figure 2.6. Payments for long-term care services increased steadily from fiscal year 1973 to fiscal year 1983. Inpatient hospital services and the remaining Medicaid services also increased, but less rapidly.

Table 2.6

Medicare benefit payments by type of coverage, Medicaid payments by basis of eligibility, and percent change in total from previous year: 1966–83

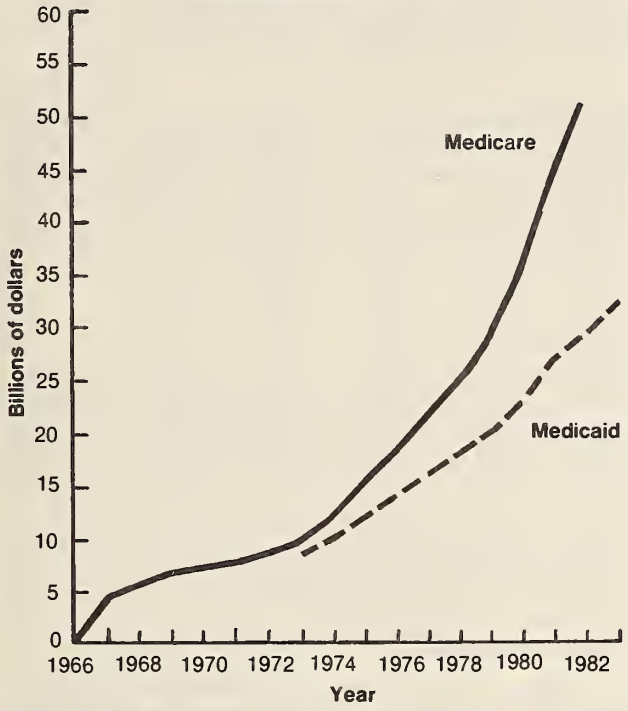
	Medicare benefit payments				Medicaid payments				
		Coverage			Basis of eligibility				
Year[1]	Total	Hospital insurance	Supplementary medical insurance	Percent change	Total	AFDC[2]	SSI[3]	Other	Percent change
	Amount in millions				Amount in millions				
1966[4]	$1,019	$891	$128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	446.5	—	—	—	—	—
1968	5,697	4,179	1,518	25.2	—	—	—	—	—
1969	6,603	4,739	1,865	15.9	—	—	—	—	—
1970	7,099	5,124	1,975	7.5	—	—	—	—	—
1971	7,868	5,751	2,117	10.8	—	—	—	—	—
1972	8,643	6,318	2,325	9.9	—	—	—	—	—
1973[5]	9,583	7,057	2,526	10.9	$8,640	$2,872	$5,315	$452	NA
1974	12,418	9,099	3,318	30.2	9,983	5,093	6,159	425	15.5
1975	15,588	11,315	4,273	24.9	12,242	4,248	7,503	492	22.6
1976	18,420	13,340	5,080	18.2	14,091	4,719	8,830	542	15.1
1977	21,774	15,737	6,038	18.2	16,239	5,216	10,382	641	15.2
1978	24,934	17,682	7,252	14.5	17,992	5,421	11,929	643	10.8
1979	29,331	20,623	8,708	17.6	20,472	5,905	13,928	638	13.8
1980	35,699	25,064	10,635	21.7	23,311	6,354	16,361	596	13.9
1981	43,455	30,342	13,113	21.7	27,204	7,271	19,381	552	16.7
1982	51,086	35,631	15,455	17.6	29,399	7,567	21,144	689	8.1
1983	—	—	—	—	32,351	8,305	23,320	725	10.0
				Percent					
ACRG[6]	[7]17.5	[7]17.0	[7]18.6	NA	14.1	11.2	15.9	4.8	NA

[1] Medicare data are for calendar years; Medicaid data are for fiscal years.
[2] Aid to Families with Dependent Children.
[3] Supplemental Security Income.
[4] July–December only.
[5] Disabled enrollees were covered by Medicare on July 1, 1973.
[6] Annual compound rate of growth.
[7] ACRG computed for 1967–82 only.

SOURCES: Medicare statistics: Board of Trustees, Federal Hospital Insurance Trust Fund: *1984 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, Apr. 5, 1984; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1984 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, Apr. 5, 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.2

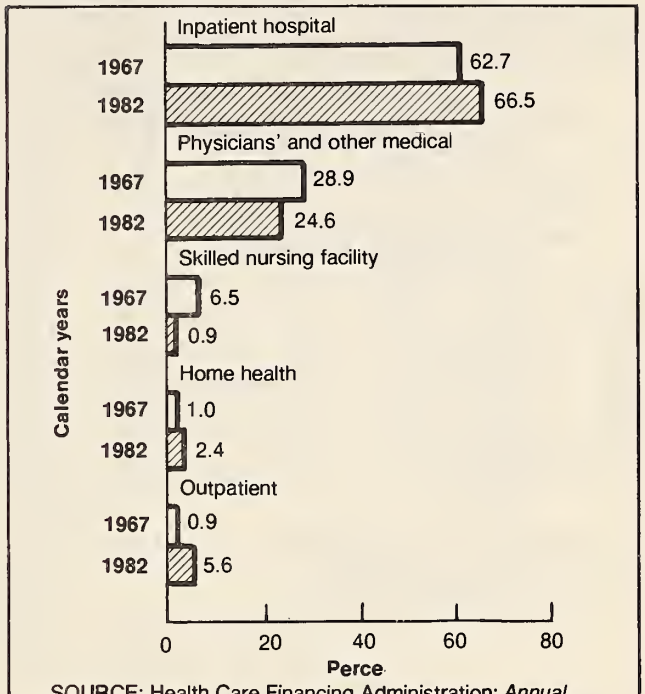
Medicare benefit payments and Medicaid payments: 1966–83



SOURCES: Medicare statistics: Board of Trustees, Federal Hospital Insurance Trust Fund: *Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund,* Apr. 5, 1984; Board of Trustees, Federal Supplementary Insurance Trust Fund: *1982 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund,* Apr. 5, 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.3

Percent distribution of Medicare reimbursements, by type of service: Calendar years 1967 and 1982



SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

Medicaid expenditures by age, sex, and race of recipients are reported in Table 2.9. As with Table 2.5, some States did not report recipients' race. From 1973 to 1983, variations in the growth of expenditures by age range from an annual average of 13.6 percent for persons 65 years of age or over to 16.4 percent for children under the age of 6. Increases in payments on behalf of male recipients were similar to those for female recipients (14.3 and 14.0 percent, respectively).

As with Medicare, a small number of recipients consume a disproportionate share of Medicaid payments. The share of total recipients and total payments accounted for by each of five eligibility groups is shown in Figure 2.7. In fiscal year 1983, the aged accounted for 15.1 percent of all recipients and 37.0 percent of all payments. Similarly, the blind and disabled accounted for only 14.2 percent of all recipients but 35.2 percent of all payments. Together, the aged, blind, and disabled accounted for 29.3 percent of all recipients and 72.2 percent of all payments. At the opposite end of the spectrum are children in AFDC families, who accounted for 43.8 percent of all recipients but only 11.8 percent of all payments.

Short-stay hospital and physicians' services

Data on Medicare and Medicaid short-stay inpatient hospital use are presented in Table 2.10. Discharges, covered days of care, reimbursements for Medicare enrollees, and payments for Medicaid recipients are included. Disabled Medicare enrollees exhibited the highest rates of growth in discharges, days of care, and reimbursements. This reflects the rapid rate of increase in enrollment by disabled persons in the 1970's (Table 2.3).

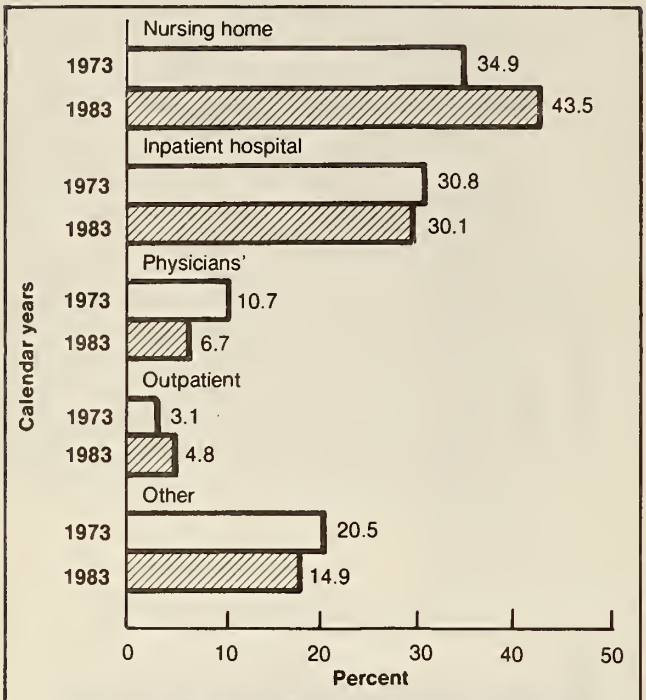
Days of care for disabled Medicare enrollees grew 8.7 percent per year. Days of care for aged Medicare enrollees grew much more slowly, 2.4 percent per year. For short-stay hospital services, the rate of growth of Medicare reimbursements for the aged (16.5 percent) and the disabled (24.7 percent) increased faster than the rate of Medicaid payments (12.7 percent).

Data on Medicare reimbursements and Medicaid payments for physicians' services are reported in Table 2.11. Like inpatient hospital services, reimbursement for physicians' services grew the fastest for disabled Medicare enrollees, 29.9 percent a year from 1974 to 1982. Medicaid payments for physicians' services grew the slowest, 8.9 percent a year from 1973 to 1983.

These trends in Medicare reimbursements and Medicaid payments for general hospital and physicians' services are displayed in Figures 2.8 and 2.9. As shown

Figure 2.4

Percent distribution of Medicaid payments, by type of service: Calendar years 1973 and 1983



SOURCE: Health Care Financing Administration, Office of the Actuary: *Data from the Division of Medicaid Cost Estimates*.

in each figure, Medicaid payments have been growing more slowly than Medicare reimbursements in recent years. To some extent, this reflects the declining number of Medicaid recipients since 1977 (Figure 2.1).

Selected services

Medicare services

Medicare reimbursement trends for skilled nursing care, outpatient services, and home health services are shown in Figure 2.10. The trend line for outpatient care graphically illustrates the sharp increase in reimbursements that occurred after the entry of disabled and ESRD enrollees in 1973. More detailed information on these trends is presented in Tables 2.12, 2.13, and 2.14.

Skilled nursing facility services

Data on the use of and reimbursements for skilled nursing facility (SNF) services are presented in Table 2.12. The data are based on bills for services incurred in a calendar year. Among aged enrollees, the number of covered days of SNF care decreased by 62 percent from 1969 (the first year data were collected) to 1972 and decreased at a slower rate from 1976 to 1982. The average annual rate of decrease for covered days was 5.8 percent among the aged from 1969 to 1982. The decline resulted from administrative limitations on the Medicare SNF benefit which, by law, is targeted to enrollees requiring skilled nursing services but not custodial care. In 1982, the disabled accounted for only 3.3 percent of total Medicare-covered days in SNF's. From 1974 (the first full year of coverage) to 1982, the number of covered days of care used by the disabled increased at an annual average rate of 0.3 percent.

Among the aged, the decline in covered days of care resulted in reimbursement declines from 1969 to 1972; only in 1973 did reimbursements begin to rise. SNF reimbursements for the aged rose at an average annual rate of 1.5 percent during the period 1969–82. In contrast, reimbursements for the disabled rose at an average annual rate of 7.7 percent during this period.

Outpatient services

Reimbursements for outpatient care are shown in Table 2.13 and Figure 2.10. Among aged and disabled enrollees combined, outpatient reimbursements grew more rapidly than reimbursements for any other service (as derived from data shown in this chapter). The disabled accounted for nearly one-third of outpatient reimbursements, reflecting the impact of the ESRD population on the SMI program.

Home health services

Data on the use of and reimbursements for home health agency (HHA) services for the period 1969–82 are presented in Table 2.14. The rapid increase in visits and reimbursements reflects the provisions of the Omnibus Budget Reconciliation Act of 1980, which improved HHA benefits effective July 1981. It provided for unlimited HHA visits for enrollees having HI and eliminated the 3-day prior hospitalization requirement to receive services. For enrollees lacking HI coverage, the act provided unlimited visits for enrollees with SMI coverage, and they no longer needed to meet the SMI deductible before Medicare paid for services.

Services to ESRD enrollees

In Table 2.15, information is presented on reimbursements, enrollment, and per capita reimbursements for enrollees with end stage renal disease during the period 1974–82. More information on Medicare coverage can be found in Eggers (1984). In 1974, the first full year of coverage of ESRD patients, total Medicare reimbursements for the ESRD program were $229 million. By 1982, reimbursements had risen to $1,650 million, more than seven times the amount in 1974, or an annual growth rate of 28.0 percent. However, the rate of growth has slowed considerably in recent years. From 1974 to 1975, the rate of growth was 58 percent. By the most recent time period for which data are available, 1981–82, the growth had slowed to 12.2 percent.

This pattern of growth in reimbursements is largely caused by the growth in the ESRD population. There were 16,000 ESRD enrollees in 1974. By 1982, this total was 70,800, more than four times greater. Enrollment increases were also greatest in the early years of the

Table 2.7

Medicare reimbursements, by type of coverage and type of enrollee: Calendar years 1966–82

Year	Hospital insurance and supplementary medical insurance				Hospital insurance				Supplementary medical insurance			
	Total	Aged[1]	Disabled[2]	ESRD[3]	Total	Aged[1]	Disabled[2]	ESRD[3]	Total	Aged[1]	Disabled[2]	ESRD[3]
	Amount in millions											
1966–67[4]	$5,145.2	$5,145.2	NA	NA	$3,839.9	$3,839.9	NA	NA	$1,305.3	$1,305.3	NA	NA
1968	5,289.5	5,289.5	NA	NA	3,766.9	3,766.9	NA	NA	1,522.6	1,522.6	NA	NA
1969	6,267.6	6,267.6	NA	NA	4,597.4	4,597.4	NA	NA	1,670.3	1,670.3	NA	NA
1970	6,572.0	6,572.0	NA	NA	4,740.3	4,740.3	NA	NA	1,831.6	1,831.6	NA	NA
1971	7,354.4	7,354.4	NA	NA	5,358.2	5,358.2	NA	NA	1,996.2	1,996.2	NA	NA
1972	8,019.4	8,019.4	NA	NA	5,835.7	5,835.7	NA	NA	2,183.7	2,183.7	NA	NA
1973	—	9,038.7	—	—	—	6,674.3	—	—	—	2,364.3	—	—
1974	11,238.0	10,257.5	$980.5	$184.4	8,118.4	7,454.4	$664.0	$44.6	3,119.6	2,803.1	$316.5	$139.8
1975	14,548.5	13,056.1	1,492.4	346.8	10,519.1	9,537.4	981.8	93.7	4,029.4	3,518.7	510.6	253.1
1976	17,619.0	15,636.5	1,982.5	492.0	12,793.9	11,495.8	1,298.1	134.3	4,825.1	4,140.7	684.4	357.7
1977	20,476.8	18,014.7	2,462.1	614.0	14,709.9	13,116.3	1,593.6	167.4	5,766.9	4,898.4	868.5	446.6
1978	23,542.7	20,579.1	2,963.6	744.0	16,630.3	14,740.7	1,889.7	196.6	6,912.4	5,838.4	1,073.9	548.1
1979	27,699.1	24,005.0	3,694.1	950.4	19,257.9	16,940.4	2,317.4	252.4	8,441.2	7,064.5	1,376.7	698.0
1980	33,724.7	29,224.2	4,500.5	1,207.0	23,194.2	20,404.1	2,790.1	330.2	10,530.5	8,820.1	1,710.4	876.8
1981	39,918.4	36,614.0	5,304.4	1,384.3	27,486.4	24,180.5	3,305.9	413.5	12,432.0	10,433.5	1,998.5	970.8
1982	48,134.3	41,786.8	6,347.4	1,666.3	33,332.8	29,360.3	3,972.5	521.9	14,801.5	12,426.5	2,374.9	1,144.3
	Percent											
ACRG[5]	[6]17.1	[6]15.9	26.3	31.7	[6]16.9	[6]15.8	25.1	36.0	[6]17.6	[6]16.2	28.6	30.1

[1] For all enrollees 65 years of age or over, including those with end stage renal disease.
[2] For all enrollees under 65 years of age, including those with end stage renal disease.
[3] End stage renal disease. Includes all aged and disabled enrollees with ESRD.
[4] July 1966 through December 1967.
[5] Average compound rate of growth.
[6] ACRG computed for 1968–82.

NOTE: Reimbursements are amounts paid in a calendar year and are not adjusted for claims paid after data were compiled. Reimbursement data differ from benefit payments data in Table 2.6, which include both interim reimbursements and retroactive adjustments made to institutional providers.

SOURCES: Health Care Financing Administration: *Medicare: Reimbursements by State and County,* annual issues for 1966–80. Washington. U.S. Government Printing Office; Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

Table 2.8

Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal years 1973–83

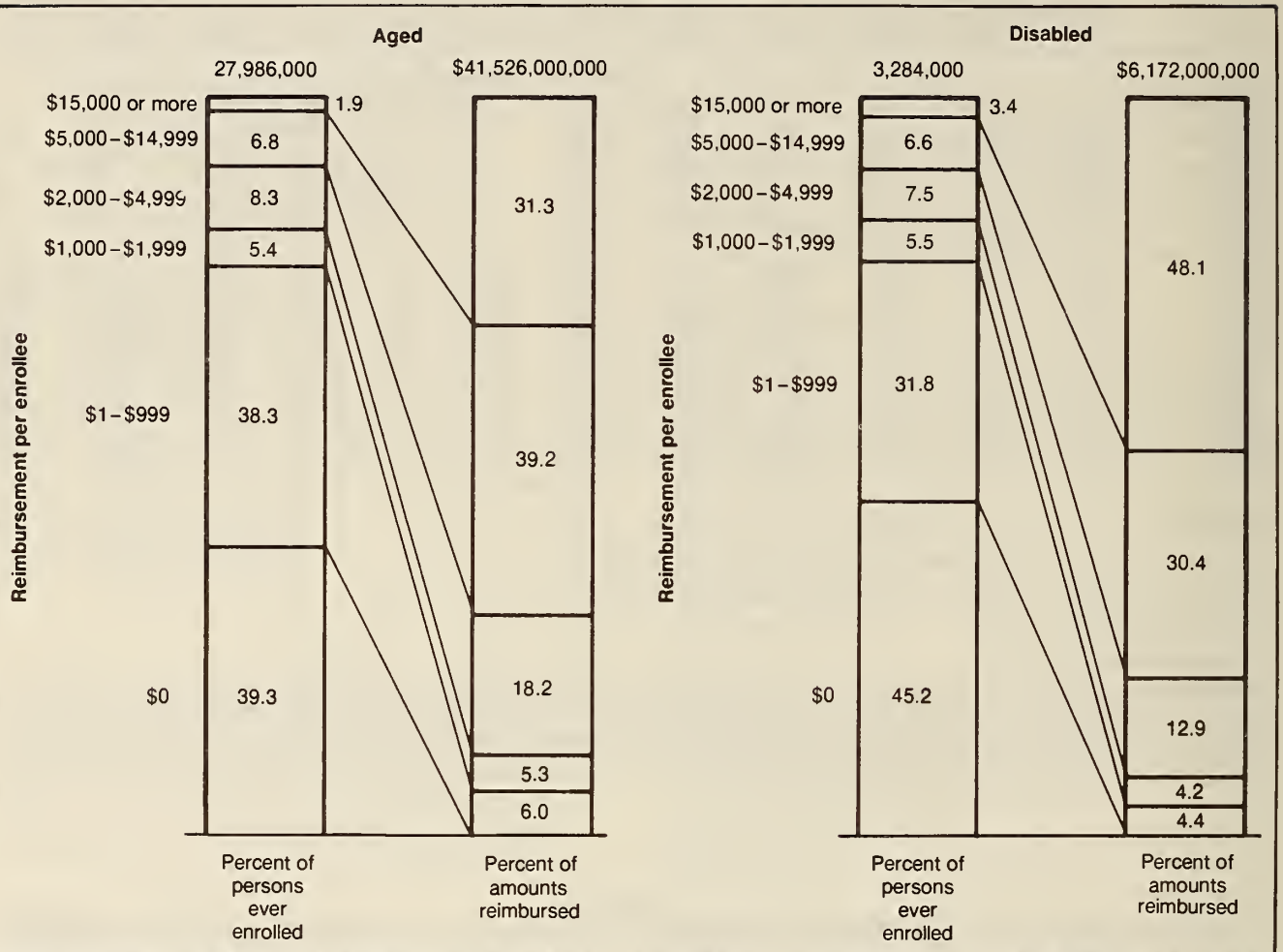
Year	Cash assistance							Medical assistance only						
		SSI[1]			AFDC[2]				SSI[1]			AFDC[2]		
	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX[4]	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX
	Amount in millions													
1973	$4,736.5	$985.0	$46.4	$1,335.6	$1,048.5	$1,277.8	$44.3	$3,903.3	$2,250.5	$18.5	$680.5	$377.6	$168.3	$407.9
1974	5,640.8	1,177.5	54.5	1,605.2	1,319.6	1,447.3	36.6	4,342.1	2,513.7	25.3	783.1	374.6	257.1	388.2
1975	7,188.3	1,340.9	60.7	2,041.6	1,850.5	1,894.7	NA	5,054.0	3,016.9	32.2	1,010.6	335.6	167.0	491.6
1976	8,154.4	1,448.2	60.4	2,486.3	2,076.1	2,083.3	NA	5,936.3	3,461.8	35.5	1,337.6	354.5	204.9	541.9
1977[5]	9,576.6	1,707.6	75.4	3,189.5	2,246.0	2,358.1	NA	6,662.3	3,791.0	40.7	1,577.8	364.3	247.9	640.7
1978[5]	10,160.0	1,799.0	74.4	3,431.5	2,439.5	2,415.5	NA	7,832.5	4,509.4	41.2	2,073.2	308.9	257.2	642.6
1979	11,281.3	1,879.4	76.0	4,020.2	2,567.1	2,738.6	NA	9,190.4	5,166.6	32.4	2,753.8	317.3	282.2	638.2
1980	12,344.1	2,196.4	87.6	4,479.1	2,698.4	2,882.6	NA	10,966.7	6,542.8	36.8	3,017.8	424.3	348.9	596.2
1981	14,534.2	2,480.2	108.5	5,615.7	3,002.2	3,327.6	NA	12,670.1	7,445.9	45.5	3,685.1	506.1	435.0	552.5
1982	15,861.6	2,705.3	120.5	6,468.0	2,978.5	3,589.3	NA	13,537.8	8,033.8	51.9	3,764.7	495.0	503.8	688.5
1983	17,089.1	3,003.9	132.6	6,863.7	3,243.1	3,845.8	NA	15,261.4	8,950.0	50.4	4,319.4	579.0	637.3	725.3
	Percent													
ACRG[6]	13.7	11.8	11.1	17.8	12.0	11.6	NA	14.6	14.8	10.5	20.3	4.4	14.2	5.9

[1] Supplemental Security Income.
[2] Aid to Families with Dependent Children.
[3] Totals for each year include estimated payments for nonreporting States. Payments by basis of eligibility may not sum to total because of rounding.
[4] Cash assistance to other Title XIX recipients was phased out after 1974.
[5] Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.
[6] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.5

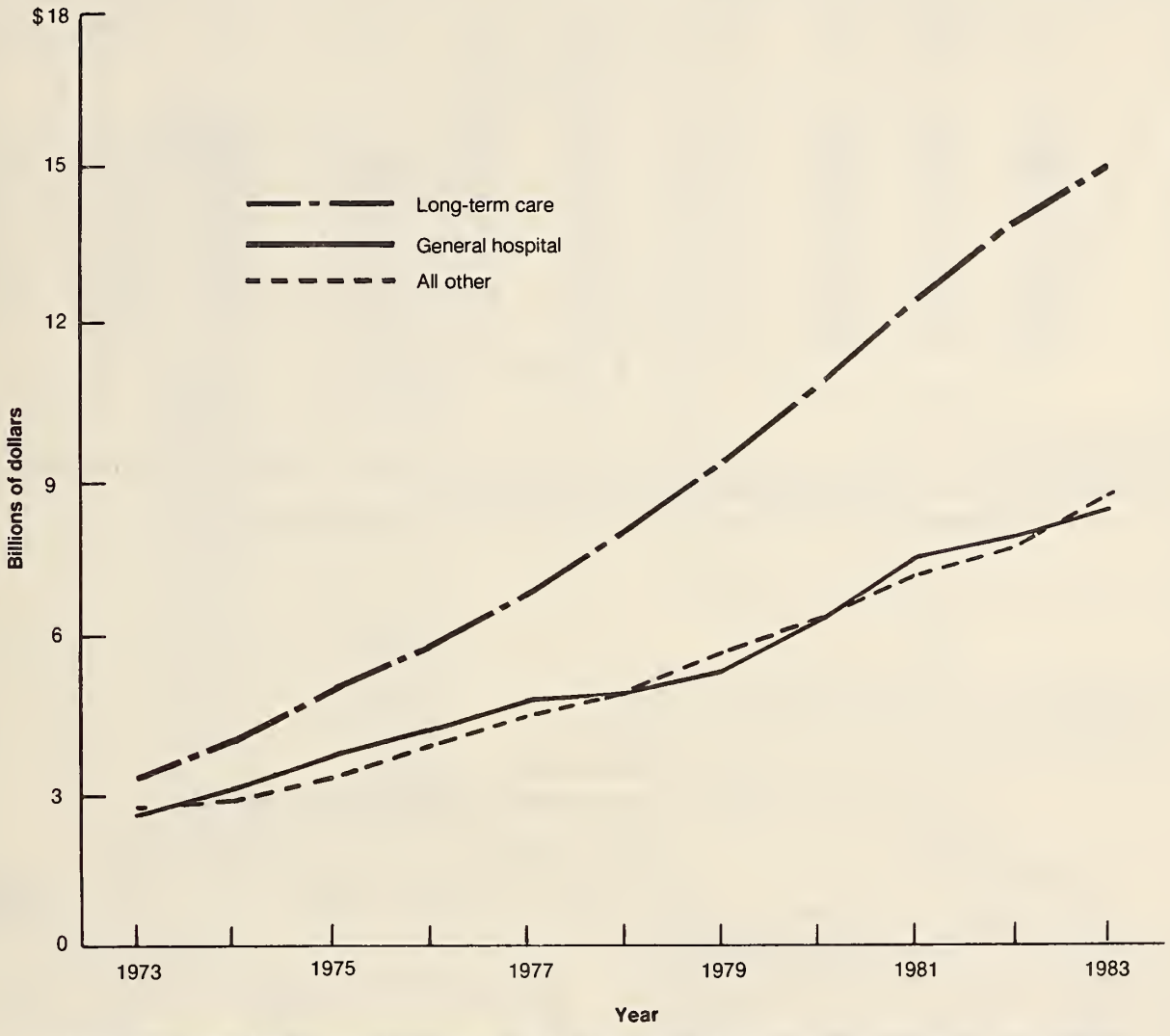
Percent distributions of aged and disabled Medicare enrollees and reimbursements per enrollee: Calendar year 1982



SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984.

Figure 2.6

Medicaid payments for long-term care, general hospital, and all other services: Fiscal years 1973 - 83



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.9

Medicaid payments, by age, sex, and race of recipient: Fiscal years 1973–83

Year	Total	Age				Sex		Race		
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	All other	Unknown
					Amount in millions					
1973	$8,640	$537.4	$1,067.9	$3,696.2	$3,338.5	$2,886.6	$5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,242	717.4	1,712.7	5,021.7	4,790.3	3,908.8	8,333.2	$5,920.0	$2,635.5	$3,686.4
1976	14,091	880.7	2,046.0	5,837.8	5,326.4	4,535.9	9,555.1	6,645.5	3,122.0	4,323.5
1977	16,239	1,000.4	2,459.2	6,865.8	5,912.7	5,274.5	10,964.5	8,134.4	3,546.1	4,558.6
1978	17,992	1,149.7	2,526.1	7,544.0	6,772.2	5,919.4	12,072.6	9,053.0	4,038.2	4,900.8
1979	20,472	1,244.5	2,712.3	8,522.0	7,993.6	6,677.9	13,794.1	11,052.0	5,271.5	4,148.5
1980	23,311	1,736.0	3,285.0	9,872.6	8,417.3	7,802.2	15,508.9	12,360.1	4,896.4	6,054.5
1981	27,204	2,040.3	3,318.9	11,099.2	10,745.5	9,113.3	18,090.7	18,634.7	6,257.0	2,312.3
1982	29,399	2,205.0	3,586.6	11,994.7	11,612.6	9,848.7	19,550.3	20,138.3	6,761.8	2,498.9
1983	32,351	2,458.6	4,043.8	13,878.4	11,969.7	11,031.5	21,319.0	22,710.1	9,640.4	—
					Percent					
ACRG[1]	14.1	16.4	14.2	14.1	13.6	14.3	14.0	18.3	17.6	—

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.10

Use of short-stay hospitals under Medicare and Medicaid: 1967–83

Year	Discharges			Covered days of care			Medicare reimbursements		Medicaid payments
	Medicare			Medicare[1]					
	Aged	Disabled	Medicaid[2]	Aged	Disabled	Medicaid[2]	Aged	Disabled	
	Number in thousands						Amount in millions		
1967	5,228	NA	—	68,487	NA	—	$ 2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	—	75,284	NA	—	5,576	NA	—
1973	6,751	—	—	77,637	—	—	6,245	—	$2,660
1974	7,033	604	—	79,770	6,378	—	7,209	$621	2,887
1975	7,285	724	3,031	80,135	7,370	22,941	8,859	876	3,374
1976	7,607	863	3,287	82,916	8,661	23,962	10,589	1,183	3,904
1977	7,850	969	3,390	85,471	9,827	25,661	12,455	1,520	4,562
1978	8,133	1,060	3,459	87,033	10,581	25,521	14,182	1,834	4,992
1979	8,478	1,164	3,546	89,075	11,446	25,022	16,251	2,212	5,655
1980	9,051	1,228	3,203	94,422	12,090	24,089	19,460	2,639	6,412
1981	9,376	1,266	3,404	95,065	12,212	26,468	22,812	3,097	7,194
1982[3]	9,913	1,310	3,393	98,268	12,389	25,670	27,223	3,642	7,670
1983	—	—	3,989	—	—	30,284	—	—	8,802
					Percent				
ACRG[4]	4.4	10.2	3.5	2.4	8.7	3.5	16.5	24.7	12.7

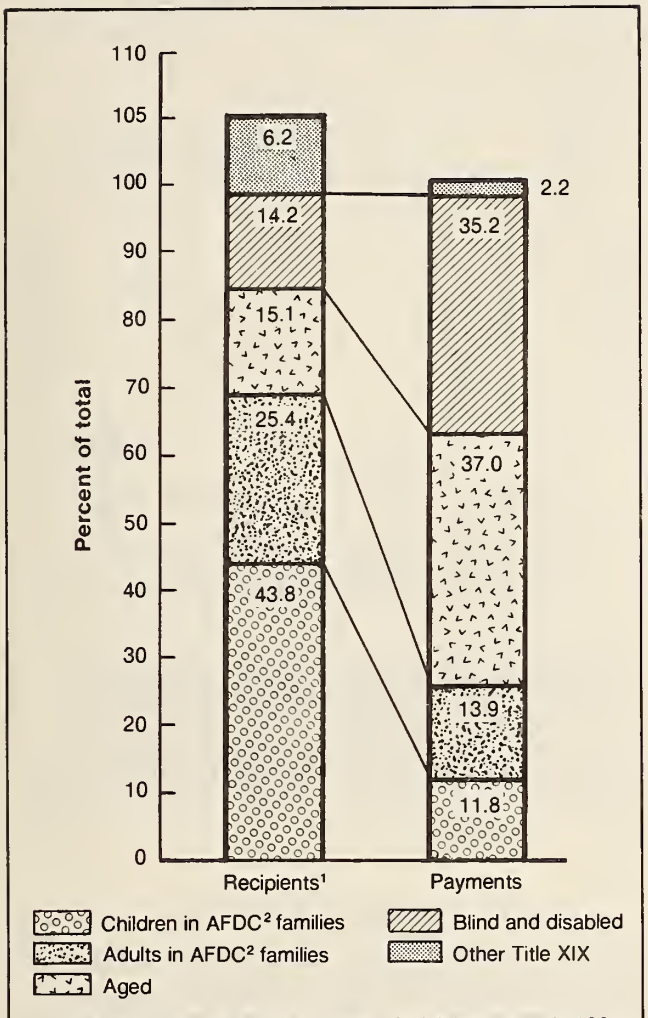
[1] Days of care covered by Medicare; covered days constitute more than 95 percent of total days of care.
[2] Data for New York State excluded from discharges and days of care for years prior to 1981.
[3] Medicare data based on discharge stay records recorded as of December 1983. Data for 1982 are understated by about 3 percent compared with earlier years.
[4] Annual compound rate of growth.

NOTES: Medicare data are for calendar years; Medicaid data are for fiscal years. Medicaid data for 1975 and later years have been revised.

SOURCES: Medicare data: Health Care Financing Administration, Office of Statistics and Data Management. Medicaid data: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.7

Percent distributions of Medicaid recipients and payments, by basis of eligibility: Fiscal year 1983



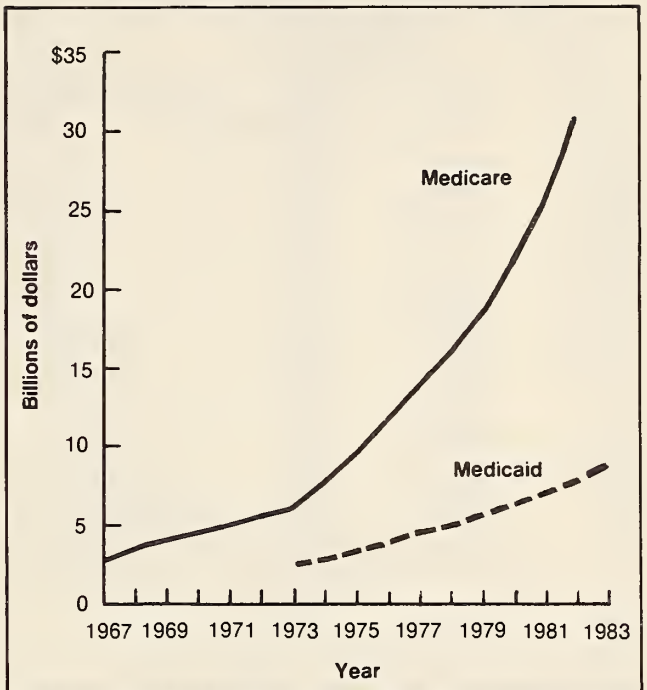
[1] The sum of percentages by basis of eligibility exceeds 100 percent because a recipient may be counted in more than one eligibility group.

[2] Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.8

Medicare reimbursements and Medicaid payments for short-stay hospital services: 1967–83



SOURCES: Medicare statistics: Health Care Financing Administration, Office of Statistics and Data Management: Unpublished data. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

program. Although the overall annual growth rate was 20.4 percent, the rate was 41.9 percent from 1974 to 1975 and only 10.5 percent from 1981 to 1982.

The growth rate in ESRD enrollees reflects the unique nature of this Medicare population. Before Medicare covered ESRD patients, most people with ESRD died because of lack of funding for the expensive dialysis maintenance therapy or for transplantation operations. Thus, in July 1973, when the ESRD program began, it mainly served people whose onset of ESRD occurred in 1973. In 1974, the program served people whose ESRD occurred in 1974 plus survivors whose treatment began in 1973. In 1975, new ESRD patients were added to cohorts from the two previous years, and so on. As enrollment has grown, the number of deaths among the carryover population has begun to approach the number of new entries because annual mortality even with dialysis is about 20 percent. Thus, the overall growth rate has slowed considerably.

Reimbursements per ESRD enrollee rose from $14,300 in 1974 to $23,300 in 1982. The annual growth rate of only 6.3 percent results largely from a cap of $138 in the allowed charge per dialysis (with some exceptions) since the program began. Dialysis reimbursements amount to about 50 percent of reimbursements for ESRD patients. The remaining 50 percent is mostly for inpatient hospital care and physicians' services, which have not been subject to a reimbursement cap.

Parceling out the growth in total ESRD reimbursements into the two components of enrollment and per capita reimbursements shows that 76 percent of the growth is caused by the increase in the enrolled population and only 4 percent by the increase in reimbursements per enrollee. (The parceling method is described in Klarman et al., 1970.)

Medicaid services

Trends in Medicaid payments for skilled nursing and intermediate care facilities are shown in Figure 2.11. Data on Medicaid payments for hospital outpatient services, home health services, and drug prescriptions are shown in Figure 2.12. Detailed information on changes in these services is presented in Tables 2.16–2.20.

Table 2.11

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1966–83

Year	Medicare reimbursements[1] Aged	Medicare reimbursements[1] Disabled	Medicaid payments
	Amount in millions		
1966[2]	$431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	$925.9
1974	2,534.0	$206.2	1,083.4
1975	3,050.0	295.2	1,225.1
1976	3,633.0	389.1	1,368.9
1977	4,177.0	481.5	1,504.7
1978	5,145.0	556.5	1,554.4
1979	6,045.0	809.7	1,635.2
1980	7,361.4	996.9	1,874.6
1981	8,688.5	1,198.9	2,101.4
1982	10,310.8	1,384.5	2,085.5
1983	—	—	2,174.6
		Percent	
ACRG[3]	[4]15.3	29.9	8.9

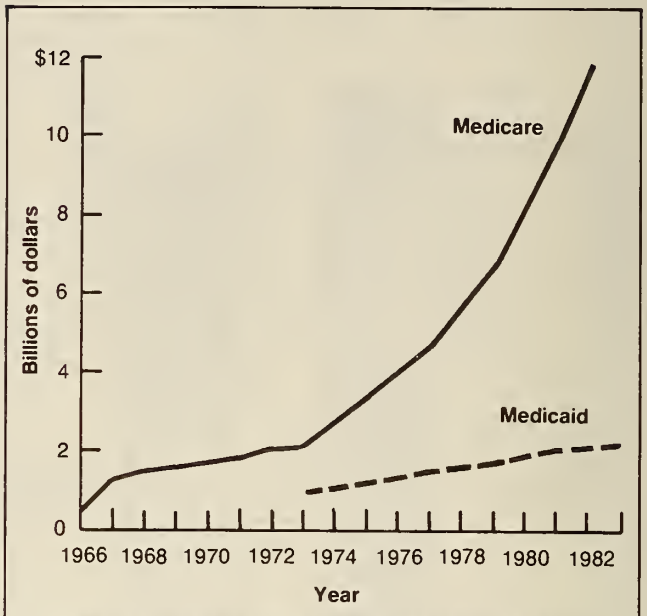
[1] Reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices are included. Therefore, these data are not directly comparable with Medicaid payments, which cover only physicians' services.
[2] July–December only.
[3] Annual compound rate of growth.
[4] ACRG computed for 1967–82 only.

NOTE: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCES: Medicare statistics: Health Care Financing Administration, Office of Statistics and Data Management; Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Figure 2.9

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1966–83



SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U. S. Government Printing Office, Dec. 1984. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.12

Medicare-covered days of care, covered charges, and reimbursements for skilled nursing facility services, by type of enrollee: Calendar years 1969–82

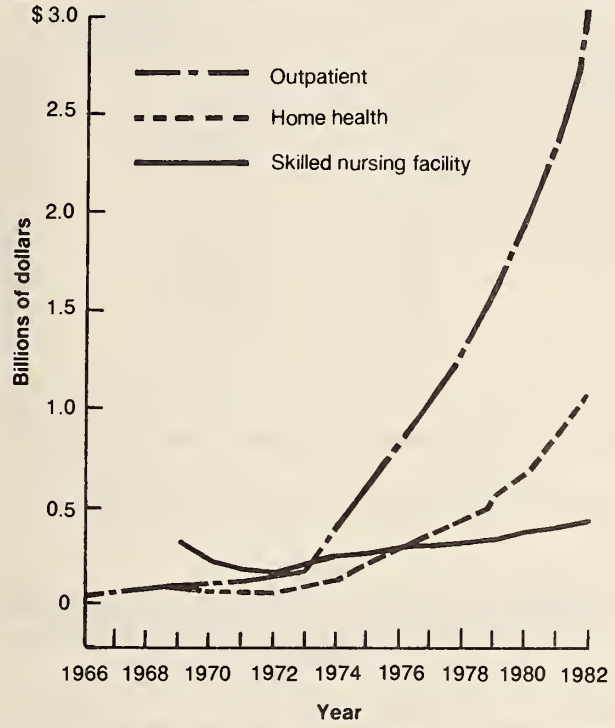
Year	Covered days of care Aged	Covered days of care Disabled	Covered charges Aged	Covered charges Disabled	Reimbursements Aged	Reimbursements Disabled
	Number in thousands		Amount in millions			
1969	17,572.5	NA	$432.2	NA	$335.0	NA
1970	10,697.1	NA	295.1	NA	225.6	NA
1971	7,481.1	NA	229.9	NA	178.7	NA
1972	6,628.0	NA	212.1	NA	164.1	NA
1973[1]	8,523.0	106.4	278.1	$4.0	209.8	$2.9
1974	8,687.9	277.0	322.9	11.8	237.6	8.3
1975	8,584.7	289.1	405.5	14.8	251.5	9.6
1976	9,406.7	316.6	448.7	17.6	293.5	11.2
1977	9,296.9	334.8	478.5	20.0	301.0	12.3
1978	8,677.1	316.9	495.9	20.9	305.1	12.6
1979	8,163.2	316.4	524.2	23.1	316.6	13.6
1980	8,191.8	308.9	584.3	24.8	345.6	14.0
1981	8,072.1	294.6	654.2	27.4	379.6	15.2
1982[2]	8,108.5	277.6	743.1	28.9	405.8	15.0
			Percent			
ACRG[3]	–5.8	[4]0.3	4.3	[4]11.8	1.5	[4]7.7

[1] July–December only for disabled enrollees.
[2] Preliminary estimates.
[3] Annual compound rate of growth.
[4] ACRG computed for 1974–82 only.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

Figure 2.10

Medicare reimbursements for selected services: Calendar years 1966–82



SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Division of Information Analysis.

Table 2.13

Medicare reimbursements for outpatient services, by type of enrollee: Calendar years 1966–82

Year	Aged	Disabled
	Amount in millions	
1966[1]	$38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	$145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
1979	997.1	582.9
1980	1,260.7	700.7
1981	1,556.6	791.3
1982	1,981.6	909.5
	Percent	
ACRG[2]	[3]26.7	27.0

[1] July–December only.
[2] Annual compound rate of growth.
[3] ACRG computed for 1967–82 only.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

Table 2.14

Medicare visits and reimbursements for home health services: Calendar years 1969–82

Year	Visits in thousands	Reimbursements in millions
1969	8,500	$78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
1979	20,000	542.1
1980	22,600	665.7
1981	26,200	859.4
1982[1]	30,800	1,104.7
	Percent	
ACRG[2]	10.4	22.6

[1] Preliminary estimates.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

Skilled nursing facilities and intermediate care facilities

Data on use of and payments to skilled nursing facilities under Medicaid are shown in Table 2.16. From 1973 to 1983, recipients in skilled nursing facilities and total days of care declined at annual rates of 1.7 and 0.8 percent, respectively. Both declined from 1973 to 1975 but have fluctuated since then. In spite of these fluctuations in use, payments grew steadily at an annual rate of 9.0 percent.

Data on trends in the use of and payments to intermediate care facilities during the period 1975–83 are presented in Table 2.17. Payments grew at an annual rate of 14.0 percent. The number of recipients and days of care grew more slowly, 1.9 and 2.3 percent per year, respectively.

Hospital outpatient services

Data on Medicaid utilization of hospital outpatient services during the period 1973–83 are reported in Table 2.18. The number of recipients grew 6.6 percent annually from 1973 through 1983, and payments increased almost three times as fast as number of recipients.

Home health services

As shown in Table 2.19, home health care is one of the fastest growing services covered by Medicaid. From 1973 through 1983, the number of recipients increased at an average annual rate of 14.4 percent. Payments grew at an even higher rate, 37.1 percent per year.

Table 2.15

Medicare reimbursements, enrollees, and reimbursements per enrollee for persons with end stage renal disease: Calendar years 1974–82

Year	Reimbursements		Enrollees[1]		Reimbursement per enrollee	
	Amount in millions	Percent change	Number in thousands	Percent change	Amount	Percent change
1974	$228.5	NA	16.0	NA	$14,300	NA
1975	361.1	58.0	22.7	41.9	15,900	11.2
1976	512.2	41.8	28.9	27.3	17,700	11.3
1977	641.3	25.2	34.8	20.4	18,400	4.0
1978	799.5	24.6	43.1	23.9	18,500	0.5
1979	1,010.0	26.3	50.8	17.9	19,900	7.6
1980	1,249.7	23.7	57.8	13.8	21,600	8.5
1981	1,471.5	17.7	64.1	10.9	23,000	6.5
1982	1,650.4	12.2	70.8	10.5	23,300	1.3
			Percent			
ACRG[2]	28.0	NA	20.4	NA	6.3	NA

[1] As of July 1. Includes enrollees entitled to Medicare benefits as aged or disabled persons and persons entitled by the provisions of section 299I of Public Law 92–603 as "renal only."
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the ESRD Archival Reimbursement Abstract.

Table 2.16

Medicaid recipients, days of care, and payments for skilled nursing facility services: Fiscal years 1973–83

Year	Recipients	Days of care	Payments
	Number in thousands		Amount in millions
1973[1]	678	133,905.0	$1,958.9
1974[2]	661	130,547.5	2,001.9
1975	630	120,672.5	2,434.2
1976	637	122,252.5	2,475.6
1977	641	124,622.5	2,691.2
1978	639	125,412.5	3,125.0
1979	610	117,117.5	3,379.5
1980	609	120,277.5	3,685.2
1981	623	125,412.5	4,035.4
1982	559	110,205.0	4,426.7
1983	574	123,114.5	4,621.0
		Percent	
ACRG[3]	−1.7	−0.8	9.0

[1] Includes intermediate care facilities in Michigan.
[2] Includes intermediate care facilities in West Virginia, Missouri, and North Carolina.
[3] Annual compound rate of growth.

NOTE: Estimates were made for States with missing data. Therefore, figures may differ from those in Table 4.12.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.17

Medicaid recipients, days of care, and payments for intermediate care facility services: Fiscal years 1975–83

Year	Recipients	Days of care	Payments
	Number in thousands		Amount in millions
1975	682	167,184.8	$1,885.0
1976	724	178,812.8	2,208.5
1977	754	193,283.2	2,637.2
1978	740	190,957.6	3,104.4
1979	766	194,316.8	3,773.2
1980	789	203,877.6	4,201.7
1981	762	199,484.8	4,506.7
1982	765	197,934.4	4,979.0
1983	793	201,199.3	5,380.6
		Percent	
ACRG[1]	1.9	2.3	14.0

[1] Annual compound rate of growth.

NOTES: Data exclude intermediate care facilities for the mentally retarded. Data for 1973 and 1974 are not available.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Prescription drugs

Data on use of and payments for prescription drugs under Medicaid[5] are shown in Table 2.20. Both the number of recipients and number of prescriptions grew over the period, with the growth in the number of prescriptions outpacing that of recipients. The number of prescriptions per recipient grew at a rate of 2.1 percent per year, increasing from 10.5 per recipient in 1973 to 12.9 per recipient in 1983. Payments for prescriptions grew steadily at an annual rate of 11.3 percent.

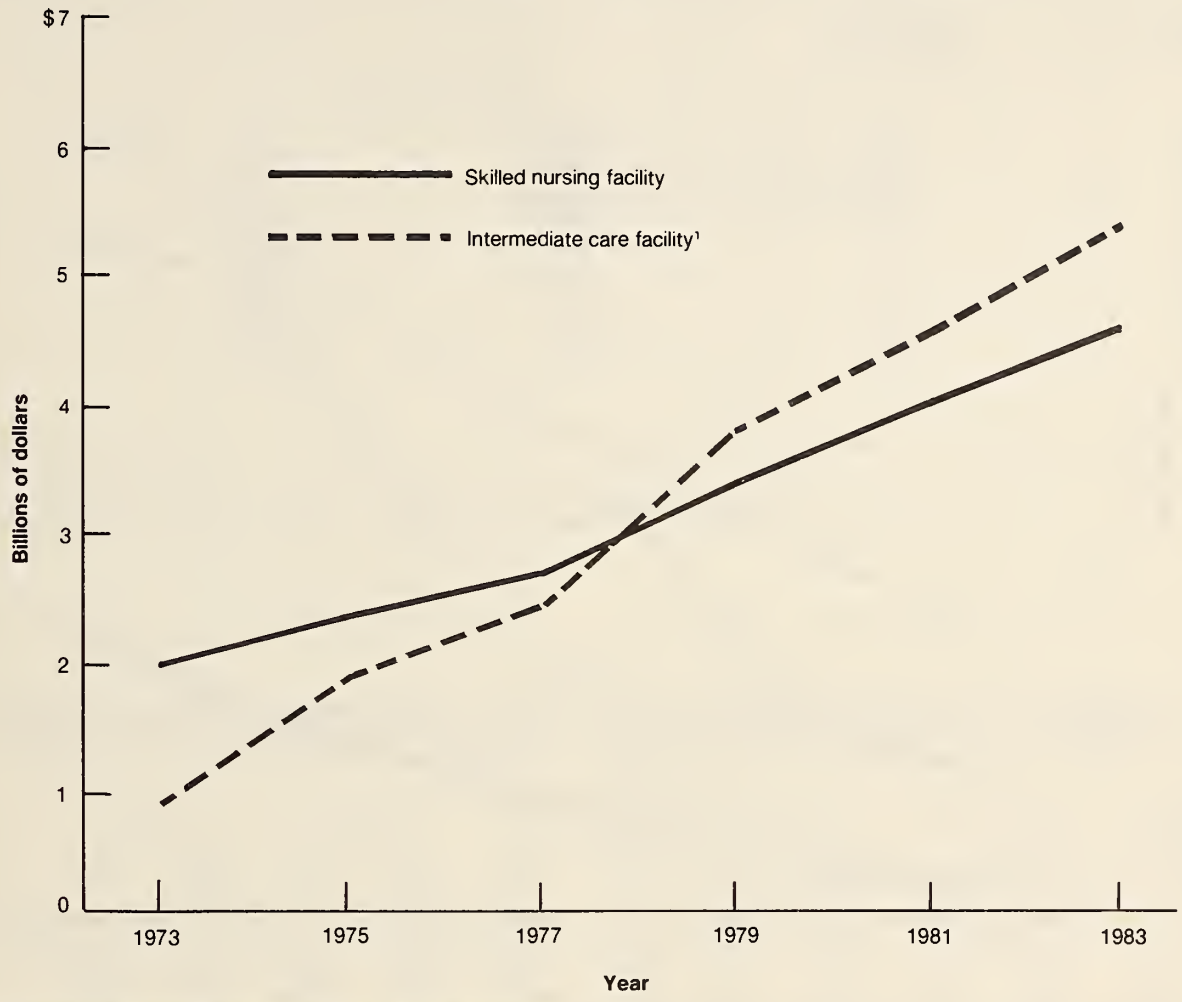
[5] Medicare does not cover the costs of drugs outside an inpatient setting.

Medicare cost sharing

Estimates of Medicare cost sharing (coinsurance and deductible) by enrollees for HI and SMI services are shown in Table 2.21. Aged and disabled Medicare enrollees who used the HI program (hospitals and SNF's) incurred $2.9 billion in cost-sharing expenses in 1982. The HI deductible accounted for 78 percent of HI enrollee liabilities for both the aged and the disabled in 1982.

Figure 2.11

Medicaid payments for nursing facility services, by type of service: Fiscal years 1973–83



[1] Excludes intermediate care facilities for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

The disabled, excluding persons entitled to Medicare solely because of ESRD, had HI liabilities per enrollee that were somewhat higher than those of the aged in each year beginning with 1977. As can be derived from Table 2.21, from 1977 to 1982, HI liabilities of aged and disabled enrollees rose at an average annual rate of 22 percent. The increase was primarily caused by rising hospital charges, as reflected in the increase in the deductible from $124 per benefit period in 1977 to $260 in 1982 and the accompanying increase in the coinsurance amount.

Total liabilities for SMI services in 1982 are estimated at $5.4 billion. Because the SMI deductible is a fixed annual amount, $60 for the years 1973–81 and $75 since 1982, deductibles accounted for only 30 percent of total liabilities for all enrollees in 1982. As derived from Table 2.21, SMI liabilities increased at an average annual rate of nearly 17 percent from 1977 to 1982.

Overview of current program issues

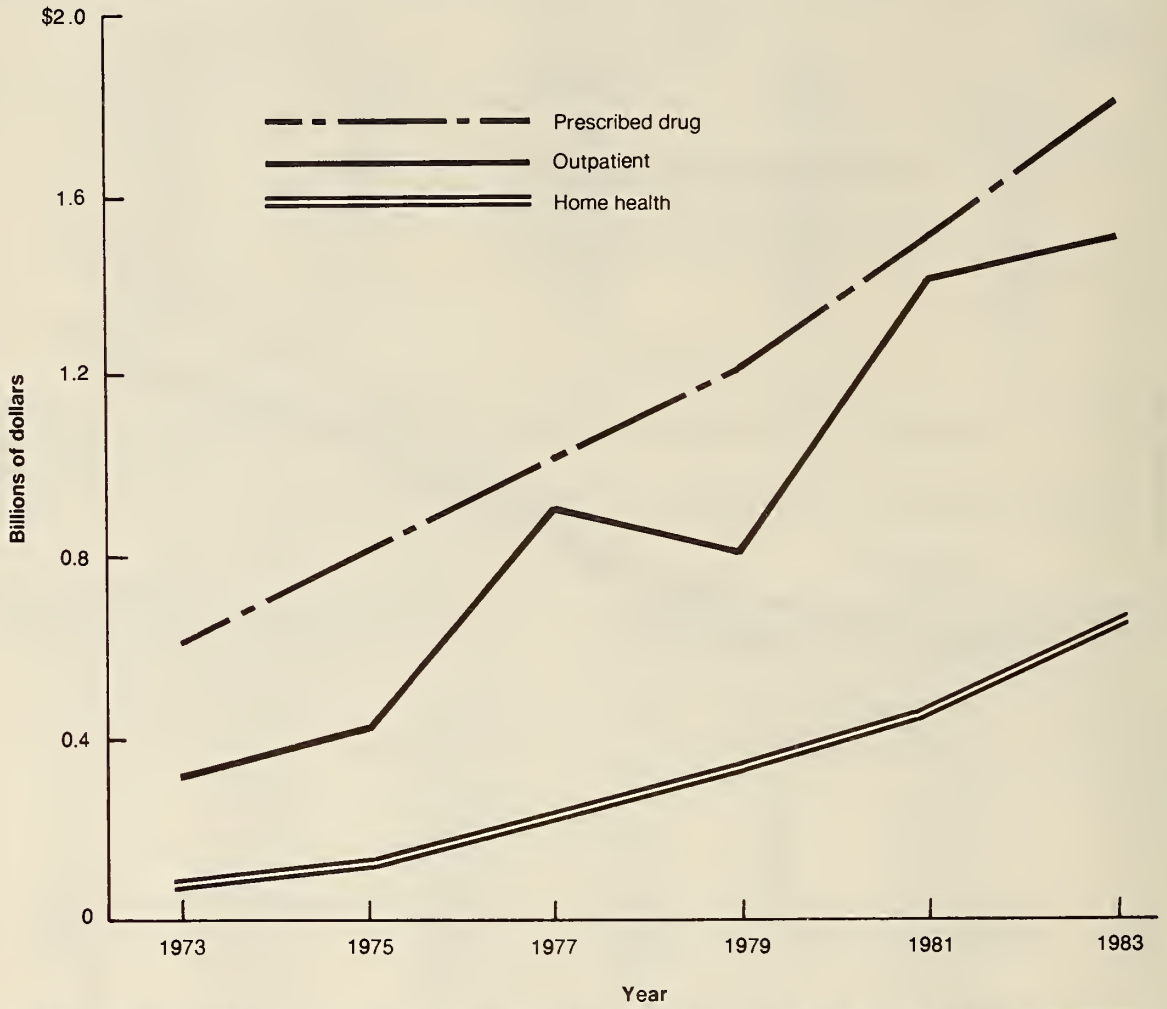
This section is a review of the major program issues and health system changes and options in the health care system. The material is based on an article in the *Health Care Financing Review* (Gornick et al., 1985).

Medicare issues

In the early years of the Medicare program, the major emphases were on expanding health care for the aged and extending access to the disabled and persons with end stage renal disease. As health care expenditures consistently rose at a much higher rate than the Consumer Price Index, the emphasis shifted to developing policies to control costs and promote cost effectiveness. Congress mandated studies and experiments to develop new methods for paying hospitals that would help to control health care expenditures.

Figure 2.12

Medicaid payments for selected services: Fiscal years 1973–83



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.18

Medicaid recipients and payments for hospital outpatient services: Fiscal years 1973–83

Year	Recipients in thousands	Payments in millions
1973	5,295.4	$267.6
1974	5,544.5	322.0
1975	7,436.8	372.8
1976	8,482.2	555.3
1977	8,618.9	876.6
1978	8,628.0	834.6
1979	7,710.4	847.4
1980	9,704.9	1,101.1
1981	10,017.9	1,409.1
1982	9,852.5	1,437.7
1983	10,007.9	1,544.9
	Percent	
ACRG[1]	6.6	19.2

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.19

Medicaid recipients and payments for home health services: Fiscal years 1973–83

Year	Recipients in thousands	Payments in millions
1973	109.9	$25.4
1974	134.7	31.1
1975	342.8	70.0
1976	319.2	134.1
1977	370.8	180.0
1978	376.5	210.0
1979	358.9	263.5
1980	392.4	332.0
1981	401.7	427.8
1982	377.3	495.5
1983	421.8	597.2
	Percent	
ACRG[1]	14.4	37.1

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.20

Selected measures of use of prescription drugs under Medicaid: Fiscal years 1973–83

Year	Recipients	Prescriptions	Number of prescriptions per recipient	Payments in millions
	Number in thousands			
1973	12,116.2	127,293.4	10.5	$609.3
1974	14,240.0	143,179.5	10.1	712.6
1975	14,155.4	154,701.1	10.9	814.9
1976	14,883.3	170,287.8	11.4	939.6
1977	15,369.9	173,891.1	11.3	1,018.2
1978	15,187.8	176,991.2	11.7	1,081.7
1979	14,282.9	177,657.2	12.4	1,196.3
1980	13,707.4	169,457.2	12.4	1,318.3
1981	14,255.7	176,215.0	12.4	1,534.7
1982	13,546.7	175,830.8	13.0	1,598.9
1983	13,726.5	177,436.8	12.9	1,771.2
		Percent		
ACRG[1]	1.3	3.4	2.1	11.3

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 2.21

Hospital insurance and supplementary medical insurance cost-sharing deductible and coinsurance amounts for Medicare aged and disabled enrollees: United States, calendar years 1977–82

	Cost sharing											
	Total		Deductible		Coinsurance[1]		Total		Deductible		Coinsurance[1]	
Year	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
Hospital insurance				Amount in millions					Amount per enrollee[2]			
1977	$972	$119	$756	$88	$216	$31	$42	$46	$33	$34	$9	$12
1978	1,161	150	907	112	254	38	49	54	38	40	11	14
1979	1,333	179	1,035	133	298	46	55	62	43	46	12	16
1980	1,595	212	1,239	156	356	56	65	72	50	53	14	19
1981	1,836	244	1,434	181	402	63	73	82	57	61	16	21
1982[3]	2,588	325	2,037	240	551	85	101	110	79	81	21	29
						Percent						
ACRG[4]	21.6	22.3	21.9	22.2	20.6	22.4	19.2	19.1	19.1	19.0	18.5	19.3
Supplementary medical insurance				Amount in millions					Amount per enrollee[2]			
1977	$2,210	$305	$966	$81	$1,244	$224	$96	$129	$42	$34	$54	$95
1978	2,469	369	1,009	90	1,460	279	105	146	43	36	62	110
1979	2,801	445	1,059	99	1,742	346	117	168	44	37	73	131
1980	3,213	528	1,102	105	2,111	423	131	195	45	39	86	156
1981	3,721	617	1,154	108	2,567	509	148	225	46	39	102	186
1982[3]	4,691	747	1,507	141	3,184	606	183	275	59	52	124	223
						Percent						
ACRG[4]	16.3	19.6	9.3	11.7	20.7	22.0	13.8	16.4	7.0	8.9	18.1	18.6

[1] Includes coinsurance payments for both hospitals and skilled nursing facilities.
[2] Based on average annual enrollment.
[3] Preliminary estimates.
[4] Annual compound rate of growth.

NOTES: Excludes cost-sharing payments of end stage renal disease patients. Data may be revised.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

The 1972 Amendments to the Social Security Act, in addition to extending Medicare coverage to the disabled and persons with end stage renal disease, enacted several cost-control measures. These included establishing professional standards review organizations to review the care given to all federally funded patients. A major goal of professional standards review organizations was to eliminate unnecessary hospital days. The amendments also permitted Medicare enrollees to have their health care provided by health maintenance organizations (HMO's). Congress enacted this option because HMO's had been found to have lower rates of hospital use than fee-for-service care and to promote preventive care. The amendments also set forth additional guidelines on what costs are reasonable, limited costs based on those incurred by similar providers in a locality, and authorized withholding payments to hospitals for unreasonable expenses.

Congress also enacted the National Health Planning and Resources Development Act of 1974. This legislation established health systems agencies to oversee area-wide health planning and resource development and required certificates of need for hospital capital reimbursement.

Health care expenditures were put under mandatory control beginning August 1971 under the Economic Stabilization Program, but controls were lifted April 30, 1974. Health care costs then began to rise rapidly.

The next legislation to control health expenditures was the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA), Public Law 97–248. TEFRA set limits on Medicare reimbursements for hospital costs based on case mix and mandated the development of a national prospective payment system (PPS). TEFRA also established payment limits based on cost per case rather than per diem cost and introduced a Medicare case-mix index. Congress next enacted the Social Security Act Amendments of 1983 (Public Law 98–21). These amendments provided for a phased-in implementation of PPS based on a diagnosis-related group rate-setting system for Medicare hospital reimbursement. Based on preliminary analysis of admission, discharge, and length-of-stay data, PPS appears to be the first legislation that effectively controls health care costs.

In addition to seeking ways to control the rate of inpatient hospital reimbursements, efforts are underway to control physician payments. Medicare initially attempted to control outlays by establishing reasonable charges, deductibles, and copayments. The 1972 amendments added the Medicare Economic Index, explained in detail in Chapter 3. However, the rate of growth of reimbursements to physicians has nearly equaled that of inpatient hospital reimbursements. The Deficit Reduction Act of 1984 placed a "freeze" on Medicare maximum payment levels for physicians for 15 months beginning July 1984. Further, physicians who accepted assignment were given incentives, and as a result, the assignment rate has risen.

In reform of the payment system for physicians' services, capitation is likely to be used as the basic payment mechanism. The objective would be to have a single capitated payment for physician, hospital, and other Medicare-covered services. Demonstrations of various capitated approaches are currently being developed. The Health Care Financing Administration requires that the contractors performing these demonstrations consider quality, beneficiary access, enrollee liability, and cost effectiveness.

Medicaid issues

Medicaid expenditures also increased rapidly from the program's inception, with the medically needy population a major contributor to the rise. The 1972 amendments also stimulated the growth in expenditures. This legislation expanded services to the mentally retarded in intermediate care facilities and increased the number of disabled eligible for Medicaid. The growth of Medicaid expenditures became a major concern of Federal, State, and local governments.

The Omnibus Budget Reconciliation Act of 1981 (OBRA) made several changes to control growth in Medicaid spending by giving States new options. Section 2176 of OBRA allowed States to institute a variety of less costly home and community-based services for recipients who otherwise would be placed in long-term care institutions. (Long-term care is a major proportion of Medicaid outlays.) OBRA granted States increased flexibility in establishing methods of reimbursement to help control inpatient hospital costs (section 2173). Under section 2175 of OBRA, States were allowed to institute programs (with and without waivers) to reduce costs by limiting the Medicaid provision that guarantees freedom to choose any provider, practitioner, or supplier of health services. Section 2172 permitted States to reduce the number of Medicaid-eligible persons aged 18–20 years. Section 2161 provided for reducing the total Federal reimbursement for each State in fiscal years 1982–84. In addition, TEFRA permitted States to impose nominal copayments, with certain limitations, to reduce program outlays and discourage unnecessary use of services.

3. Medicare: Description and data

In this chapter, detailed information on the Medicare program is presented. This program for financing health care for the aged was enacted on July 30, 1965, as Title XVIII of the Social Security Act. Benefits began on July 1, 1966. The Medicare program (Health Insurance for the Aged) was substantially expanded by the 1972 Amendments to the Social Security Act (Public Law 92-603). These amendments (effective July 1, 1973) extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or a kidney transplant for end stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. Major changes in the Medicare law through the Deficit Reduction Act of 1984 (Public Law 98-369), which became law on July 18, 1984, are described in this report.

The Secretary of the Department of Health and Human Services (DHHS) has overall responsibility for the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) administers Medicare. Medicare consists of two separate but complementary insurance programs: hospital insurance (HI) and supplementary medical insurance (SMI). HI covers inpatient hospital and skilled nursing facility services, and SMI covers physicians' and related services for eligible persons who voluntarily pay premiums or whose premiums are paid for them.

In the next four sections, eligibility standards, benefits, financing, and administration are described for both HI and SMI. Analysis of the distribution of benefits is presented according to the following formula:

$$\frac{\text{Persons served}}{\text{Enrollees}} \times \frac{\text{Reimbursements}}{\text{Persons served}} = \frac{\text{Reimbursements,}}{\text{Enrollees}}$$

where

- Persons served are persons who exceeded deductibles (HI or SMI) and were reimbursed by Medicare for services received;
- Persons served/enrollees is the proportion of enrollees who exceeded deductibles and were reimbursed for covered services;
- Reimbursements/persons served is the average Medicare reimbursement for persons who received Medicare reimbursements;
- Reimbursements/enrollees is the average Medicare reimbursement for a population group.

In the final sections of this chapter, the Medicare program's arrangements with health care prepayment plans and health maintenance organizations are discussed and the Medicare statistical system is described.

Eligibility

All persons 65 years of age or over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the HI program. Effective July 1, 1973, disabled persons entitled to cash benefits under the social security or railroad retirement program are also eligible for HI benefits. A person must be entitled to 24 months of cash benefits and be disabled for 5 calendar months before disability benefits begin. Thus, Medicare coverage begins the 30th month after the first full calendar month of disability.

HI protection also extends to persons who have end stage renal disease (ESRD) and require renal dialysis or a kidney transplant, if they are currently insured, entitled to monthly social security benefits, or are the spouses or dependent children of such insured persons. Eligibility for coverage begins the third month after renal dialysis treatments begin or before this qualifying dialysis period for ESRD enrollees who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant or after dialysis treatment has been terminated.

The 1972 amendments, effective July 1973, permit most persons 65 years of age or over who are ineligible for HI coverage to enroll voluntarily by paying a monthly premium. This "premium-HI" was set at $226 a month for 1987 and represents the full premium cost of HI. The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) changed the end of the 12-month premium-HI adjustment period from June 1983 to December 1983; premium adjustments are now for a calendar year. To obtain premium-HI, the enrollee must also obtain SMI coverage. The Omnibus Budget Reconciliation Acts of 1980 and 1981 made the premium-HI enrollment procedure the same as the SMI procedure (discussed next). As a result, effective April 1981, aged enrollees may terminate and reenroll an unlimited number of times. However, they may enroll or reenroll only during January through March of each year. In addition, the 1982 TEFRA extended Medicare coverage to Federal employees and required them to pay for HI.

Persons entitled to benefits under the HI program and most other persons 65 years of age or over may voluntarily enroll in SMI. Only the aged can enroll in SMI without being eligible for HI; disabled persons may not. The Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, instituted a general enrollment period, which occurs from January through March of each year. Coverage becomes effective July 1. Persons may terminate SMI enrollment by not paying premiums. A person may reenroll by paying a surcharge of 10 percent for every 12 months that he or she could have been enrolled. Coverage will begin again on July 1. Under the State buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

Data on the total number of aged and disabled persons enrolled in Medicare (HI and/or SMI) in 1981 and 1982 are shown in Table 3.1. Total Medicare

enrollees, 90 percent of whom were aged, numbered 29.5 million in 1982. Ninety-eight percent of the aged were enrolled in both HI and SMI or only in HI. The remainder, 425,000 aged who were ineligible for HI, were enrolled only in SMI. Ninety-two percent of disabled HI enrollees were also enrolled for SMI.

In Table 3.2, the number of aged and disabled enrollees in 1982 for both HI and SMI is shown by census region and division. For both aged and disabled groups, the greatest number of enrollees resided in the South, and the smallest number resided in the West. Detailed information on the distribution of HI and SMI benefits for aged and disabled enrollees is presented in Tables 3.3. and 3.4. Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits (persons served per 1,000 enrollees). For both groups, average reimbursements per person served were far higher for HI than for SMI. The proportions of both aged and disabled enrollees receiving benefits were higher for older age groups for both HI and SMI.

Benefits

Overview

The HI program covers inpatient hospital care and posthospital care in skilled nursing facilities (SNF's). The program also covers home health agency services for persons confined to the home who need skilled nursing care or physical or speech therapy. To be covered, services must be provided by institutions and organizations that have been certified as qualified providers and have agreements to participate in the program. Exceptions to this rule are made for emergency services.

Table 3.1

Number of aged and disabled Medicare enrollees, by type of coverage: July 1, 1981 and 1982

Type of enrollee	Hospital insurance and/or supplementary medical insurance		Hospital insurance		Supplementary medical insurance	
	1981	1982	1981	1982	1981	1982
	Number in thousands					
Total	29,010.0	29,494.2	28,589.5	29,069.0	27,941.2	28,412.3
Aged[1]	26,011.0	26,540.0	25,590.6	26,114.8	25,181.7	25,706.8
Disabled[2]	2,999.0	2,954.2	2,999.0	2,954.2	2,759.5	2,705.5

[1] All enrollees 65 years of age or over, including enrollees with end stage renal disease (ESRD).
[2] All enrollees under 65 years of age, including enrollees with ESRD.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.2

Number of Medicare enrollees, by type of coverage, type of enrollee, census region and division: July 1, 1982

Census region and division	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]
All areas	29,494,219	26,539,994	2,954,208	29,068,966	26,114,758	2,954,208	28,412,282	25,706,792	2,705,490
United States[2]	28,885,227	26,036,365	2,848,862	28,461,136	25,612,291	2,848,845	28,135,041	25,477,813	2,657,228
Northeast	6,799,790	6,173,740	626,050	6,712,641	6,086,596	626,045	6,636,983	6,056,173	580,810
New England	1,698,576	1,558,578	139,998	1,679,668	1,539,671	139,997	1,656,006	1,528,273	127,733
Middle Atlantic	5,101,214	4,615,162	486,052	5,032,973	4,546,925	486,048	4,980,977	4,527,900	453,077
North Central	7,527,140	6,863,772	663,368	7,453,327	6,789,963	663,364	7,357,094	6,741,596	615,498
East North Central	5,107,682	4,624,539	483,143	5,053,069	4,569,928	483,141	4,989,956	4,541,828	448,128
West North Central	2,419,458	2,239,233	180,225	2,400,258	2,220,035	180,223	2,367,138	2,199,768	167,370
South	9,618,627	8,532,898	1,085,729	9,433,711	8,347,986	1,085,725	9,345,103	8,326,984	1,018,119
South Atlantic	4,972,768	4,419,283	553,485	4,879,411	4,325,927	553,484	4,835,560	4,316,395	519,165
East South Central	1,917,989	1,666,885	251,104	1,874,998	1,623,894	251,104	1,866,927	1,629,679	237,248
West South Central	2,727,870	2,446,730	281,140	2,679,302	2,398,165	281,137	2,642,616	2,380,910	261,706
West	4,913,393	4,443,010	470,383	4,836,891	4,366,512	470,379	4,774,394	4,334,574	439,820
Mountain	1,234,585	1,122,715	111,870	1,220,785	1,108,916	111,869	1,193,001	1,090,121	102,880
Pacific	3,678,808	3,320,295	358,513	3,616,106	3,257,596	358,510	3,581,393	3,244,453	336,940

[1] Includes disabled enrollees under age 65 with end stage renal disease and enrollees with end stage renal disease only.
[2] Includes 50 States, District of Columbia, and unknown residence.

NOTE: This table is based on data recorded in the Medicare health insurance master file on March 30, 1983.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.3

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1982

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
		Reimbursements			Reimbursements			Reimbursements	
	Persons served per 1,000 enrollees	Per person served	Per enrollee	Persons served per 1,000 enrollees	Per person served	Per enrollee	Persons served per 1,000 enrollees	Per person served	Per enrollee
Total	641.4	$2,439	$1,565	256.7	$4,462	$1,119	653.8	$733	$479
Age									
65–69 years	579.1	2,043	1,183	191.7	4,183	802	592.4	687	407
70–74 years	626.3	2,320	1,453	229.5	4,416	1,013	635.9	745	474
75–79 years	677.7	2,608	1,767	277.0	4,622	1,280	686.3	774	531
80–84 years	711.6	2,851	2,029	323.8	4,642	1,503	723.3	756	547
85 years or over	733.0	2,960	2,170	360.8	4,591	1,656	758.1	720	545
Sex									
Male	610.8	2,717	1,660	259.3	4,546	1,179	624.6	821	513
Female	662.0	2,267	1,501	244.9	4,401	1,078	673.1	678	456
Race									
White	648.1	2,415	1,565	253.4	4,390	1,112	658.7	729	480
All other	585.8	2,739	1,604	229.4	5,264	1,208	611.2	784	479
Census region									
Northeast	690.7	2,419	1,671	238.2	4,946	1,178	697.8	744	519
North Central	625.9	2,579	1,614	266.8	4,533	1,209	629.5	675	425
South	627.5	2,313	1,451	269.4	3,866	1,041	634.7	698	443
West	677.0	2,532	1,714	226.9	5,098	1,157	683.1	866	592

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.4

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1982

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
		Reimbursements			Reimbursements			Reimbursements	
	Persons served per 1,000 enrollees	Per person served	Per enrollee	Persons served per 1,000 enrollees	Per person served	Per enrollee	Persons served per 1,000 enrollees	Per person served	Per enrollee
Total	608.9	$3,431	$2,089	256.9	$5,110	$1,313	650.1	$1,303	$848
Age									
Under 35 years	511.9	4,005	2,050	196.1	6,056	1,187	545.9	1,727	943
35–44 years	548.9	3,593	1,972	219.0	5,330	1,167	596.0	1,500	894
45–54 years	597.0	3,500	2,090	258.8	4,966	1,285	647.2	1,379	892
55–59 years	614.5	3,309	2,034	266.0	4,926	1,310	657.3	1,202	790
60–64 years	677.0	3,236	2,191	289.8	4,983	1,444	711.5	1,127	802
Sex									
Male	555.6	3,362	1,868	237.8	4,991	1,187	598.7	1,257	753
Female	700.2	3,525	2,469	289.7	5,276	1,529	736.5	1,365	1,006
Race									
White	611.2	3,279	2,004	259.0	4,968	1,287	654.4	1,199	785
All other	599.3	4,170	2,500	246.9	5,827	1,439	635.5	1,810	1,150
Census region									
Northeast	667.5	3,327	2,221	247.6	5,530	1,369	705.9	1,301	918
North Central	616.6	3,676	2,266	275.4	5,504	1,516	649.6	1,245	809
South	585.8	3,284	1,924	278.2	4,359	1,213	610.5	1,242	758
West	671.6	3,656	2,455	236.8	6,133	1,452	707.2	1,517	1,073

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Prior to the Omnibus Budget Reconciliation Act of 1980, the HI program covered home health visits only if they followed a hospital stay. Home health visits that did not follow a hospital stay were covered by the SMI program. Coverage was limited to 100 visits per benefit period for HI and 100 visits in a calendar year for SMI. The 1980 law, effective July 1, 1981, eliminated the HI requirement for prior hospitalization and the limits on visits. Under the new law, all home health visits are covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits are covered by the SMI program.

The SMI program covers a variety of medical services and supplies furnished by physicians or other health care professionals in connection with physicians' services. It also covers outpatient and home health services.

Counts of the number of institutional providers participating in Medicare in 1983 are presented in Table 3.5. Most of the Nation's hospitals participated in Medicare, and they constituted the largest class of participating providers (6,687 hospitals with 1.1 million beds). Hospitals also received the largest share of Medicare reimbursements. As shown in Table 3.6, almost all HI benefit payments and 65 percent of total Medicare payments went for hospital inpatient services in 1983. SMI benefit payments accounted for 32 percent of total payments; 78 percent of SMI payments were for physicians' services. The distribution of payments differed for aged and disabled enrollees. Disabled enrollees received a smaller proportion of HI payments and a larger proportion of SMI payments than aged enrollees.

Information on the distribution of specific benefits for aged and disabled enrollees is presented in Tables 3.7 and 3.8. In 1982, the proportion of aged enrollees receiving all listed benefits was successively higher for each age group. Among the aged, the largest proportion by far received physicians' services, followed by outpatient and inpatient hospital services. Very small proportions of aged enrollees received SNF or home health benefits.

Among the aged, larger proportions of white enrollees received reimbursements for all services except outpatient and home health services, for which the proportions were greater for enrollees of all other races. Aged enrollees of all other races had higher reimbursements per person served than aged white enrollees for all except physicians' services. With the exception of inpatient hospital benefits, a larger proportion of aged women than men received benefits. For all aged enrollees, reimbursement per person served was highest for inpatient hospital services ($4,391), followed by skilled nursing facility services ($1,591) and home health agency services ($926). Reimbursements per person served for physicians' and outpatient services were $631 and $265, respectively.

For each service, the amount reimbursed per person served was higher for the disabled than for the aged. Outpatient reimbursements per disabled person served were much higher than those for the aged because of the higher proportion of ESRD patients among the disabled.

Among the disabled, smaller proportions of white persons than all other persons received home health and outpatient benefits. However, reimbursements per person served were consistently higher for all other persons than for white persons for all services. Larger proportions of disabled women than men received all types of benefits. Reimbursements per person served were also consistently higher for disabled women than men except for SNF services.

Table 3.5

Number of facilities participating in Medicare and number of Medicare beds, by type of facility: July 1, 1976–83

Type of facility	1976	1977	1978	1979	1980	1981	1982	1983	Percent change 1976–83
Facilities					Number				
Hospitals	6,802	6,806	6,797	6,801	6,777	6,736	6,742	6,687	–1.7
Short-stay	6,112	6,131	6,130	6,128	6,104	6,065	6,070	6,048	–1.0
Long-stay:									
Psychiatric	401	400	400	411	408	412	419	430	7.2
All other	251	239	241	244	265	259	253	209	–27.3
Skilled nursing facilities	3,928	4,002	4,749	4,963	5,052	5,258	5,408	5,760	46.6
Home health agencies	2,361	2,420	2,605	2,788	2,924	3,110	3,415	4,235	79.4
Independent laboratories	3,194	3,221	3,281	3,373	3,447	3,484	3,581	3,708	16.1
Beds									
Hospitals	1,149,122	1,162,990	1,142,248	1,147,498	1,149,997	1,147,324	1,150,479	1,143,544	–0.5
Short-stay	922,601	953,067	965,323	985,070	990,621	997,020	1,012,490	1,021,086	10.7
Psychiatric	188,288	172,949	145,376	133,106	131,276	123,527	112,168	96,870	–48.6
Other long-stay	32,479	29,390	27,827	27,069	28,100	26,777	25,821	25,588	–33.1
Skilled nursing facilities	309,790	349,650	418,246	419,835	436,007	457,692	488,495	519,551	67.7

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

Table 3.6

Medicare benefit payments, by type of enrollee, type of coverage, and type of service: Calendar year 1983

Type of coverage and type of service	All enrollees		Aged		Disabled	
	Amount in millions	Percent distribution	Amount in millions	Percent distribution	Amount in millions	Percent distribution
Total	$57,443	100.0	$50,134	100.0	$7,309	100.0
Hospital insurance	39,337	68.5	34,741	69.3	4,596	62.9
Inpatient	37,183	64.7	32,733	65.3	4,450	60.9
Skilled nursing facility	515	0.9	497	1.0	18	0.2
Home health agency	1,639	2.9	1,511	3.0	128	1.8
Supplementary medical insurance	18,106	31.5	15,393	30.7	2,713	37.1
Physicians'	14,062	24.5	12,420	24.8	1,642	22.5
Outpatient	3,379	5.9	2,382	4.8	997	13.6
Home health agency	30	Z	29	Z	1	Z
Group practice plan	410	0.7	362	0.7	48	0.7
Independent laboratory[1]	225	0.4	200	0.4	25	0.3

[1] Includes only services billed directly by providers.

NOTE: Total, hospital insurance, and supplementary medical insurance benefit payments are actual amounts reported in Medicare trust fund reports. Distributions by service are preliminary estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicare Cost Estimates.

Table 3.7

Persons served and reimbursements for aged Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1982

Characteristic	Hospital insurance						Supplementary medical insurance		
	Inpatient hospital services			Skilled nursing facility services			Physicians' and other medical services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	242.7	$4,391	$1,066	9.3	$1,591	$15	635.9	$631	$401
Age									
65–69 years	188.4	4,138	780	2.5	1,646	4	571.6	584	334
70–74 years	224.0	4,353	975	5.2	1,716	9	618.3	634	392
75–79 years	268.4	4,535	1,217	10.2	1,670	17	669.9	666	446
80–84 years	310.1	4,552	1,411	18.7	1,539	29	707.8	667	472
85 years or over	338.4	4,524	1,531	29.4	1,506	44	743.1	638	474
Sex									
Male	253.2	4,484	1,135	7.2	1,546	11	606.1	712	432
Female	235.7	4,324	1,019	10.8	1,612	17	655.6	581	381
Race									
White	245.7	4,318	1,061	9.7	1,578	15	642.7	632	406
All other	218.5	5,224	1,142	5.9	1,804	11	573.7	623	357
Census region									
Northeast	227.7	4,898	1,115	8.8	1,784	16	672.2	638	429
North Central	259.9	4,472	1,162	11.1	1,601	18	610.3	577	352
South	262.0	3,784	992	7.1	1,515	11	620.7	613	381
West	220.0	5,002	1,100	12.8	1,473	19	669.9	733	491

Table 3.7—Continued

Persons served and reimbursements for aged Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1982

Characteristic	Supplementary medical insurance			Hospital insurance and/or supplementary medical insurance		
	Outpatient services			Home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	290.4	$265	$77	41.1	$926	$38
Age						
65–69 years	266.3	274	73	19.6	925	18
70–74 years	284.5	284	81	31.8	936	30
75–79 years	303.7	276	84	49.1	939	46
80–84 years	313.6	237	74	69.0	906	63
85 years or over	332.3	214	71	88.0	922	81
Sex						
Male	280.1	288	81	35.5	917	33
Female	297.2	251	75	44.9	931	42
Race						
White	288.9	253	73	40.4	903	36
All other	310.4	386	120	49.8	1,113	55
Census region						
Northeast	349.2	257	90	54.9	860	47
North Central	295.2	247	73	36.0	812	29
South	247.9	247	61	37.9	1,040	39
West	291.2	343	100	37.4	1,009	38

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.8

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1982

Characteristic	Hospital insurance						Supplementary medical insurance		
	Inpatient hospital services			Skilled nursing facility services			Physicians' and other medical services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	250.1	$5,109	$1,278	2.6	$1,762	$5	617.8	$828	$512
Age									
Under 35 years	192.1	6,087	1,170	0.8	2,074	2	500.4	893	447
35–44 years	213.4	5,333	1,138	1.4	1,992	3	558.9	845	472
45–54 years	252.6	4,966	1,254	2.0	1,727	3	614.6	853	525
55–59 years	259.2	4,916	1,274	2.8	1,633	5	629.2	815	513
60–64 years	281.0	4,976	1,398	4.2	1,773	7	682.4	798	544
Sex									
Male	231.9	5,002	1,160	2.2	1,805	4	564.4	818	462
Female	281.3	5,261	1,480	3.4	1,713	6	706.2	842	594
Race									
White	252.5	4,964	1,253	2.7	1,720	5	625.7	816	510
All other	238.9	5,852	1,398	2.4	1,969	5	583.3	894	521
Census region									
Northeast	238.6	5,545	1,323	2.4	2,040	5	657.6	807	531
North Central	268.6	5,522	1,483	3.7	1,789	7	615.7	799	492
South	272.1	4,345	1,183	1.9	1,546	3	583.7	802	468
West	231.3	6,115	1,414	3.8	1,738	7	681.1	961	654

Table 3.8—Continued

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage, type of service, and demographic characteristics: Calendar year 1982

Characteristic	Supplementary medical insurance			Hospital insurance and/or supplementary medical insurance		
	Outpatient services			Home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	362.9	$926	$336	27.1	$1,109	$30.08
Age						
Under 35 years	354.8	1,397	496	12.7	1,256	15.94
35–44 years	365.1	1,156	422	18.5	1,414	26.13
45–54 years	374.5	982	368	23.4	1,173	27.40
55–59 years	356.4	778	277	28.8	1,096	31.57
60–64 years	362.0	711	257	37.9	1,010	38.28
Sex						
Male	329.0	884	291	21.3	1,060	22.60
Female	419.0	981	411	37.1	1,157	42.88
Race						
White	355.3	773	275	26.1	1,108	28.93
All other	403.0	1,561	629	32.0	1,115	35.67
Region						
Northeast	428.8	903	387	37.2	1,102	41.04
North Central	372.2	852	317	26.4	978	25.79
South	317.9	912	290	23.5	1,163	27.30
West	393.3	1,064	418	25.7	1,216	31.20

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Hospital insurance

The law governing the HI program limits coverage to a benefit period (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been an inpatient in a hospital or skilled nursing facility for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on the number of days covered.

HI covers up to 90 days of services in a participating hospital during a single benefit period. After an initial deductible for each benefit period, the patient is entitled to 60 days of hospitalization with no additional cost sharing. From the 61st through the 90th day in the benefit period, the patient is responsible for coinsurance ($130 per day in 1987) equal to one-fourth of the deductible. The Secretary of DHHS is required each year to determine the deductible amount using a formula specified by law. Reflecting increases in hospital costs, the deductible has risen from $40 in 1966 to $520 in 1987.

HI enrollees also have a "lifetime reserve" of 60 additional hospital days, which can be used at their option when the 90 days covered in a benefit period have been exhausted. Lifetime reserve days require a coinsurance equal to one-half the deductible ($260 for each lifetime reserve day in 1987).

The HI program also pays nonparticipating hospitals for emergency services. The hospital may bill the program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient must pay for services received and submit a claim for reimbursement. Reimbursements are subject to a deductible and coinsurance.

Hospital services covered under HI include room and board in "semiprivate" accommodations containing from two to four beds. Private accommodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital. Nursing services (except private-duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients are also covered. The HI program covers the services of interns and resident physicians in approved teaching programs. Services of other physicians, including hospital-based specialists such as radiologists, anesthesiologists, and pathologists, are covered under SMI. Hospital benefits also include reimbursement for inpatient services provided by tuberculosis hospitals and psychiatric hospitals. There is a 190-day lifetime limit for psychiatric hospitals.

Prior to the Social Security Amendments of 1983 (Public Law 98–21), effective October 1, 1983, the HI program paid hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs were determined after services had been delivered and were based on program regulations. The Medicare law and regulations specified the kinds of hospital costs allowed. Medicare, for example, does not cover private-duty nursing or costs unrelated to patient care.

Once a hospital's total allowable costs were determined, Medicare apportioned the cost between Medicare patients and other patients. Medicare then paid allowable costs based on services received by Medicare patients.

The Social Security Amendments of 1983 established prospective payments for Medicare inpatient hospital services that drastically changed the way hospitals are paid. This legislation reformed the retrospective cost-based reimbursement system for inpatient care, through which payments were made for "reasonable costs" incurred during the preceding year. The new prospective payment system establishes one price for each of 467 diagnosis-related groups (DRG's). Based on diagnosis and other characteristics, the DRG system classifies patients into clinically coherent and homogeneous groups that use similar resources. Prices are established in advance for the coming year, and hospitals are paid these prices regardless of the costs they actually incur. Hospitals earn a profit when their costs fall below the prospective payment or absorb a loss when their costs are above the prospective payment. It is hoped that the prospective payment system will provide incentives for hospitals to control costs. The prospective payment system was phased in over a 3-year period beginning October 1983.

TEFRA of 1982 provided a new HI benefit, hospice care for the terminally ill. A hospice is a public agency or private organization primarily engaged in providing pain relief, symptom management, and supportive services to the terminally ill and their families. Congress authorized this benefit for 3 years beginning November 1, 1983. Congress made hospice care a permanent benefit on April 7, 1986, by removing the reference to the end date of this benefit. Medicare patients who qualify can receive a full range of medical and support services for their terminal condition. Hospice care is a comprehensive home-care program for the terminally ill. Medicare-covered services include physicians' services, skilled nursing care, medical appliances and supplies, outpatient drugs for symptom management and pain relief, home health aide and homemaker services, medical social services, counseling, and short-term inpatient care, including inpatient respite care.

To qualify for hospice benefits, a patient must have HI coverage, and his or her doctor and the hospice medical director must certify that the patient has a terminal illness and a prognosis of 6 or fewer months to live. Patients who elect this benefit must waive the standard Medicare HI benefits for services relevant to the terminal illness. Medicare will reimburse only hospice care provided by a Medicare-certified hospice. If the patient's attending physician is not employed by the hospice, SMI pays 80 percent of allowed charges after the deductible is met for physicians' services.

Under the hospice benefit, Medicare beneficiaries do not pay deductibles. Copayments may be collected by the hospice for only two items: a $5 maximum for each outpatient prescription for drugs and medications to manage symptoms and relieve pain and 5 percent of the cost for inpatient respite care up to the amount of the HI deductible. Respite care is a special benefit to provide a short-term inpatient stay to relieve family members or others primarily responsible for providing care to the patient at home.

Data on the use of and charges and reimbursements for inpatient hospital services are presented in Tables 3.9, 3.10, and 3.11. In 1982, there were 11.3 million Medicare inpatient hospital discharges (Table 3.9). These discharges resulted in reimbursements of $31.2 billion for 113 million covered days of care. Short-stay hospital care accounted for 99 percent of all discharges and reimbursements and for 98 percent of covered days of care. Aged enrollees, who represented 90 percent of all HI enrollees, used 88 percent of all covered days of care. Discharges per 1,000 enrollees, covered days of care per 1,000 enrollees, and average reimbursements per enrollee were lower for the aged than the disabled.

In Tables 3.10 and 3.11, data are presented on the use of short-stay hospitals by aged and disabled enrollees, respectively. For both these groups, discharges per 1,000 enrollees and covered days of care per 1,000 increased with age. For all enrollees (aged and disabled combined), the discharge rate of men exceeded that of women. The discharge rate for both aged and disabled white persons exceeded that for persons of all other races. However, aged and disabled enrollees of other races had longer average lengths of stay and higher covered charges per discharge and per covered day of care than white enrollees. By region, both aged and disabled enrollees in the South had the highest discharge rate but the lowest covered charge per discharge and per covered day of care. For both aged and disabled enrollees, the West had the highest covered charge per covered day of care but the lowest average length of stay.

In Table 3.12, the number of enrollees discharged from short-stay hospitals is shown by rank order for the 20 DRG's with the largest number of discharges in 1984. Also shown is the rank order of the same DRG's in 1983. Total discharges for all DRG's are also shown. The total number of discharges decreased 8.1 percent, from 11.5 million in 1983 to 10.6 million in 1984. This was a substantial decrease.

The DRG system began in October 1983, and by the end of 1984, most short-stay hospitals were subject to it. From the start of the Medicare program, the number of discharges from short-stay hospitals had increased each year (Table 2.10). The reasons for the 1983–84 decrease are unclear, but it may be related to greater use of hospital outpatient care and care from other types of providers. The average length of stay also fell a full day, from 9.8 days in 1983 to 8.8 days in 1984. Length of stay of Medicare enrollees has steadily declined since Medicare began. The drop of a full day in a year indicates an acceleration of this trend, as the previous largest decline was only one-half of a day (based on unpublished Medicare data).

The rank order of 19 of the 20 leading DRG's also changed from 1983 to 1984. DRG 127 (heart failure and shock) ranked first in both years. DRG 182 (esophagitis and related disorders for persons 70 years of age or over) moved from third place in 1983 to second

Table 3.9

Use of inpatient hospital services by Medicare enrollees, by type of enrollee and type of hospital: Calendar year 1982

Type of enrollee and type of hospital	Discharges		Covered days of care			Reimbursements			
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
All enrollees									
All hospitals	11,328	390	113,100	10.0	3,891	$31,241	$2,758	$276	$1,075
Short-stay	11,223	386	110,657	9.9	3,807	30,865	2,750	279	1,062
Long-stay	105	4	2,443	23.3	84	375	3,571	154	13
Psychiatric	64	2	1,464	22.9	50	176	2,750	120	6
All other	40	1	980	24.5	34	199	4,975	203	7
Aged									
All hospitals	9,973	382	99,742	10.2	3,819	27,474	2,755	275	1,052
Short-stay	9,913	380	98,268	9.9	3,763	27,223	2,746	277	1,042
Long-stay	60	2	1,474	24.6	56	250	4,167	170	10
Psychiatric	27	1	659	24.4	25	88	3,259	134	3
All other	33	1	816	24.7	31	162	4,909	199	6
Disabled									
All hospitals	1,355	459	13,358	9.9	4,522	3,767	2,780	282	1,275
Short-stay	1,310	443	12,389	9.5	4,194	3,642	2,780	294	1,233
Long-stay	45	15	969	21.5	33	125	2,778	129	42
Psychiatric	37	13	805	21.8	27	88	2,378	109	30
All other	7	2	164	23.4	56	37	5,286	226	13

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File.

Table 3.10

Use of short-stay hospital services by aged Medicare enrollees, by demographic characteristics: Calendar year 1982

Characteristic	Aged hospital insurance enrollees in thousands[1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	26,115	9,913	380	98,268	9.9	3,763	$40,797	$4,116	$415	$1,562
Age										
65–66 years	3,515	955	272	8,539	8.9	2,429	3,896	4,080	456	1,108
67–68 years	3,405	998	293	9,102	9.1	2,673	4,094	4,102	450	1,202
69–70 years	3,118	995	319	9,229	9.3	2,960	4,075	4,095	442	1,307
71–72 years	2,808	967	344	9,231	9.5	3,287	4,008	4,138	434	1,425
73–74 years	2,540	952	375	9,266	9.7	3,648	3,955	4,154	427	1,557
75–79 years	4,940	2,101	425	21,191	10.1	4,290	8,756	4,168	413	1,772
80–84 years	3,176	1,562	492	16,504	10.6	5,196	6,423	4,112	389	2,022
85 years or over	2,612	1,383	529	15,206	11.0	5,822	5,591	4,043	368	2,141
Sex										
Male	10,538	4,266	405	41,008	9.6	3,891	18,374	4,307	448	1,744
Female	15,577	5,647	363	57,260	10.1	3,676	22,423	3,971	392	1,439
Race[2]										
White	23,104	8,871	384	86,822	9.8	3,758	35,908	4,048	414	1,554
All other	2,265	766	338	8,688	11.3	3,836	3,741	4,884	431	1,652
Census region										
Northeast	6,087	2,085	343	24,563	11.8	4,035	9,920	4,758	404	1,630
North Central	6,790	2,760	406	27,952	10.1	4,117	11,211	4,062	401	1,651
South	8,348	3,517	421	32,922	9.4	3,944	12,440	3,537	378	1,490
West	4,367	1,489	341	12,250	8.2	2,805	7,094	4,764	579	1,624

[1] As of July 1, 1982.
[2] Excludes unknown race.

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File.

Table 3.11

Use of short-stay hospital services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1982

Characteristic	Disabled hospital insurance enrollees in thousands[1]	Discharges		Covered days of care			Covered charges			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	2,954	1,310	443	12,389	9.5	4,194	$5,485	$4,187	$443	$1,857
Age										
Under 35 years	378	130	344	1,265	9.7	3,347	573	4,408	453	1,516
35–44 years	386	147	381	1,385	9.4	3,588	593	4,034	428	1,536
45–54 years	622	285	458	2,624	9.2	4,219	1,148	4,028	438	1,846
55–59 years	635	290	457	2,723	9.4	4,288	1,205	4,155	443	1,898
60–64 years	934	457	489	4,391	9.6	4,701	1,965	4,300	448	2,104
Sex										
Male	1,865	765	410	7,040	9.2	3,775	3,219	4,208	457	1,726
Female	1,089	544	500	5,349	9.8	4,912	2,266	4,165	424	2,081
Race[2]										
White	2,400	1,079	450	10,001	9.3	4,167	4,373	4,053	437	1,822
All other	497	204	410	2,129	10.4	4,284	993	4,868	466	1,998
Census region										
Northeast	626	256	409	2,801	10.9	4,474	1,217	4,754	434	1,944
North Central	663	317	478	3,181	10.0	4,798	1,391	4,388	437	2,098
South	1,086	532	490	4,739	8.9	4,364	1,884	3,541	398	1,735
West	470	193	411	1,563	8.1	3,326	964	4,995	617	2,051

[1] As of July 1, 1982.
[2] Excludes unknown race.

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File.

Table 3.12

Short-stay hospital discharges, by rank order of the 20 diagnosis-related groups with the most discharges in 1984: Calendar years 1983 and 1984

Diagnosis-related group number and description	1984			1983		
	Discharges		Average length of stay	Discharges		Average length of stay
	Number in thousands	Rank order		Number in thousands	Rank order	
All diagnosis-related groups	10,609.4	NA	8.8	11,547.3	NA	9.8
20 leading diagnosis-related groups	4,437.4	NA	8.2	4,394.9	NA	9.4
127 Heart failure and shock	503.6	1	8.7	457.5	1	10.1
182 Esophagitis, gastroenteritis, and miscellaneous digestive disorders, age greater than 69 and comorbidity or complications	364.7	2	6.1	371.8	3	7.0
039 Lens procedures	360.6	3	2.2	438.7	2	2.5
140 Angina pectoris	321.8	4	5.6	273.4	5	6.5
014 Specific cerebrovascular disorders except transient ischemic attack	309.9	5	12.4	299.4	4	15.0
089 Simple pneumonia and pleurisy, age greater than 69 and comorbidity or complications	307.7	6	9.4	262.8	7	10.9
138 Cardiac arrhythmia and conduction disorders, age greater than 69 and comorbidity or complications	207.4	7	6.3	179.3	12	7.5
088 Chronic obstructive pulmonary disease	207.3	8	8.6	273.1	6	9.7
243 Medical back problems	195.7	9	8.0	208.9	10	9.1
096 Bronchitis and asthma, age greater than 69 and comorbidity or complications	174.4	10	7.2	143.4	15	8.1
015 Transient ischemic attacks	172.0	11	6.0	158.8	14	7.1
296 Nutritional and miscellaneous metabolic disorders, age greater than 69 and comorbidity or complications	171.5	12	8.3	125.5	18	10.0
468 Unrelated operating room procedure	159.2	13	16.6	223.5	8	16.7
122 Circulatory disorders with acute myocardial infarction, without cardiovascular complications, discharged alive	154.8	14	10.3	195.4	11	11.9
336 Transurethral prostatectomy, age greater than 69 and comorbidity or complications	150.3	15	7.9	115.7	22	8.9
209 Major joint procedures	146.1	16	15.6	117.5	21	17.5
174 Gastrointestinal hemorrhage, age greater than 69 and comorbidity or complications	140.8	17	7.5	110.0	23	8.7
294 Diabetes, age 36 or greater	137.8	18	8.4	177.2	13	9.7
320 Kidney and urinary tract infections, age greater than 69 and comorbidity or complications	134.6	19	8.1	124.6	19	9.3
082 Respiratory neoplasms	117.4	20	9.7	138.4	16	10.9

SOURCE: Health Care Financing Administration, Office of Research: Data from the Division of Program Statistics.

place in 1984. Lens procedures (DRG 039) fell from second to third place from 1983 to 1984. The decline in the number of discharges for lens procedures probably resulted from a shift to performing cataract operations in outpatient rather than hospital settings and also to peer review organizations, which discouraged premature cataract surgery (Ruther and Black, to be published). Changes in the rank order of DRG's were limited to one rank higher or lower among those ranked second through sixth in 1984. After that, as the number of discharges for a particular DRG decreased, changes in rank order sometimes varied by more than one rank. For example, DRG 138 (cardiac arrhythmia and conduction disorders for persons 70 years of age or over) rose in rank from 12th to 7th from 1983 to 1984.

HI also covers services in participating skilled nursing facilities for up to 100 days in a benefit period. For the first 20 days, patients pay no coinsurance. The remaining 80 days require a coinsurance equal to one-eighth of the inpatient deductible ($65 in 1987). A beneficiary is eligible for SNF benefits only after hospitalization for at least 3 consecutive days and only if the transfer to an SNF occurs within 30 days after hospital discharge.

Data on the use of SNF's by aged and disabled enrollees in 1982 are reported in Table 3.13. Information

Table 3.13

Use of skilled nursing facilities, by type of Medicare enrollee and demographic characteristics: Calendar year 1982

Type of enrollee and characteristic	Hospital insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Aged						
Total	26,114.8	243.9	9.3	$388.0	$1,591	$14.86
Age:						
65–69 years	8,518.9	21.0	2.5	34.6	1,646	4.06
70–74 years	6,867.5	36.0	5.3	61.8	1,716	8.99
75–79 years	4,940.5	50.6	10.2	84.5	1,670	17.11
80–84 years	3,175.7	59.5	18.7	91.5	1,539	28.83
85 years or over	2,612.1	76.7	29.4	115.6	1,506	44.25
Sex:						
Male	10,537.9	76.3	7.2	117.9	1,546	11.19
Female	15,576.8	167.6	10.8	270.1	1,612	17.34
Race:[2]						
White	23,104.5	224.2	9.7	353.7	1,578	15.31
All other	2,264.9	13.3	5.9	24.0	1,804	10.61
Census region:						
Northeast	6,086.6	52.4	8.8	95.3	1,784	15.66
North Central	6,790.0	75.1	11.1	120.2	1,601	17.70
South	8,348.0	59.0	7.1	89.3	1,515	10.70
West	4,366.5	55.9	12.8	82.3	1,473	18.85
Disabled						
Total	2,954.2	7.8	2.6	13.7	1,762	4.64
Age:						
Under 35 years	377.7	0.3	0.8	0.7	2,074	1.74
35–44 years	386.0	0.5	1.4	1.1	1,992	2.83
45–54 years	622.2	1.3	2.0	2.2	1,727	3.47
55–59 years	634.5	1.7	2.8	2.9	1,633	4.50
60–64 years	933.9	3.9	4.2	7.0	1,773	7.45
Sex:						
Male	1,865.2	4.1	2.2	7.5	1,805	4.00
Female	1,089.0	3.7	3.4	6.3	1,713	5.75
Race:[2]						
White	2,399.6	6.5	2.7	11.1	1,720	4.63
All other	497.3	1.2	2.4	2.4	1,969	4.77
Census region:						
Northeast	626.0	1.5	2.4	3.0	2,040	4.85
North Central	663.4	2.5	3.7	4.4	1,789	6.61
South	1,085.7	2.0	1.9	3.1	1,546	2.86
West	470.4	1.8	3.8	3.1	1,738	6.61

[1] As of July 1, 1982.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.14

Visits, charges, and reimbursements for home health agency services, by type of Medicare enrollee, sex, and race: Calendar year 1982

Type of enrollee, sex, and race	Visits		Charges			Reimbursements		
	Number in millions	Per 1,000 enrollees	Amount in millions	Amount in millions for visits[1]	Amount per visit[1]	Amount in millions	Per visit	Per enrollee
Total[2]	30.8	1,044	$1,296.4	$1,232.7	$40.02	$1,104.7	$35.87	$37.46
Type of enrollee								
Aged	28.3	1,068	1,191.3	1,134.3	40.08	1,015.7	35.89	38.27
Disabled	2.4	826	105.1	98.3	40.96	89.0	37.08	30.13
Sex								
Male	10.8	861	462.4	435.7	40.34	390.8	36.19	31.22
Female	20.0	1,179	834.0	796.9	39.85	713.8	35.69	42.05
Race								
White	26.2	1,014	1,086.8	1,035.3	39.52	930.7	35.53	36.08
All other	3.9	1,349	177.4	167.0	42.82	146.5	37.56	51.06

[1] Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
[2] Includes unknown race.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

on persons served and reimbursements are shown by age, sex, race, and region. Overall, a much higher proportion of aged than disabled enrollees received SNF benefits—9.3 persons served per 1,000 aged enrollees, compared with 2.6 per 1,000 disabled enrollees. Reimbursements per person served, however, were 11 percent higher for the disabled than the aged. For both aged and disabled enrollees, the number of persons served per 1,000 enrollees increased with age. Among both the aged and the disabled, higher proportions of females than males received SNF benefits. For aged enrollees, rates per 1,000 enrollees were much higher among white persons than among all other persons, but reimbursements per person served were higher for all other persons than white persons. The number of persons served per 1,000 aged and disabled enrollees was lowest in the South and highest in the West. Reimbursements per person served were lowest in the South and West for both aged and disabled enrollees.

The third type of benefit covered by HI is home health agency (HHA) services for persons under the care of a physician, confined to the home, and needing part-time or intermittent skilled nursing care or therapy. Covered services include skilled nursing care; physical, occupational, or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals); the use of medical appliances; and, in certain cases, services of an intern or resident. The services must be furnished by an approved HHA.

In Table 3.14, data are presented on the use of HHA services in 1982. The number of HHA visits per enrollee was 29 percent greater for the aged than the disabled. Because reimbursements per visit were similar for both groups, reimbursements per enrollee were 27 percent higher for the aged, $38, than for the disabled, $30. Visits per 1,000 enrollees and reimbursements per enrollee were higher for females than males and higher for persons of other races than for white persons.

Supplementary medical insurance

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as part of a physician's professional services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers as well as outpatient rehabilitation, speech therapy, and physical therapy services. The 1972 amendments, effective July 1, 1973, provide for coverage of services of physical therapists in independent practice furnished in their office or the patient's home if the services are under a physician's plan. The reimbursement limit for these services was increased from $100 to $500 by the 1980 Omnibus Budget Reconciliation Act. Lastly, limited chiropractic and optometric services are also covered.

During each calendar year, enrollees must exceed the SMI deductible to be reimbursed. From 1973 through 1981, the annual deductible was $60 of reasonable charges; beginning in 1982, it was increased to $75. Until October 1981, medical expenses incurred in the last 3 months of a year were "carried over" to the following year's deductible. The "carryover" provision was eliminated by the Omnibus Budget Reconciliation Act of 1981 for expenses incurred beginning October 1981.

After the deductible is met, SMI pays 80 percent of the allowed (reasonable) charges for covered physicians' services and most other medical services. The

allowed charge is determined for each specific service and is the lowest of:

- The physician's actual charge for the service.
- The physician's customary charge for the service (the physician's 50th percentile charge level for the specific type of service).
- The prevailing charge, which is set at the 75th percentile of the customary charges for the service charged by physicians in an area defined by the carrier.

Increases in the prevailing charge are limited by the Medicare Economic Index (mandated by the Social Security Amendments of 1972). The percent increase in the Index is the maximum allowable increase in the prevailing charge for a physician's service. This percentage is based on the weighted averages of changes in general earnings levels and changes in expenses incurred by physicians in office practice.

On each claim for payment, physicians can accept or reject assignment. Accepting assignment means that the physician submits the bill to the carrier and agrees to accept 80 percent of the reasonable charge. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The physician who does not accept assignment bills the patient. The patient is responsible for the total charge of the physician. The patient submits the bill to the carrier. The carrier pays the patient 80 percent of the reasonable charge after the deductible is met.

The Deficit Reduction Act (DEFRA) of 1984 was an effort to contain Medicare physician charges. For the 15 months beginning July 1, 1984, DEFRA froze Medicare customary, prevailing, and reasonable charges for physicians' services at the levels that were in effect for the 12 months ending June 30, 1984. Congress later extended the freeze through December 31, 1986 (Omnibus Budget Reconciliation Act of 1985, Public Law 99–272).

Physicians who serve Medicare patients can choose to be participating or nonparticipating physicians. Participating physicians voluntarily sign an agreement to accept assignment for all services provided to Medicare patients for a year. Nonparticipating physicians may accept assignment on a claim-by-claim basis. Medicare furnishes incentives for physician participation, including directories of participating physicians, dissemination of the names of participating physicians by toll-free telephone lines, and electronic receipt of claims by carriers.

Participating physicians were allowed to make normal increases in their actual charges to Medicare patients during the freeze period. These normal increases did not affect Medicare payments during the freeze but were recognized by Medicare in calculations of customary charges of participating physicians after the freeze ended. Nonparticipating physicians were not permitted to increase their actual billed charges to Medicare patients during the freeze.

What effect did DEFRA have on assignment rates? Assignment rates are based on total charges of assigned claims as a percent of total charges submitted by physicians. The assignment rate rose from 55.6 percent in 1983 to 68.6 percent in 1985, primarily because of incentives to participating physicians provided by DEFRA (McMillan, Lubitz, and Newton, 1986). This was the most rapid increase in assignment rates since HCFA began collecting such charge data.

Beginning July 1, 1984, DEFRA also modified the assignment and billing options for clinical diagnostic laboratory tests. It established a fee schedule based on a percent of prevailing charges. Tests furnished by independent laboratories, independent hospital laboratories (those furnishing tests to nonhospital patients), and physicians who accept assignment are reimbursed at 100 percent of the fee schedule. Charges of independent and hospital laboratories (who must accept assignment) and participating physicians are not subject to an SMI deductible or coinsurance. Physicians not accepting assignment for laboratory tests are paid 80 percent of the fee schedule, subject to the SMI deductible and coinsurance. Outpatient treatment for mental illness is also subject to the deductible and coinsurance; benefits are limited to the lesser of 50 percent of reasonable charges or $250.

In Table 3.15, SMI data on average charges and reimbursements per enrollee are reported. Data are presented for the period 1967–82 by type of enrollee. Reimbursements were estimated by subtracting deductible and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceeded reasonable charges were excluded.

In 1967, the program reimbursed only 57 percent of reasonable costs or charges to aged enrollees. Reimbursements are 80 percent of reasonable charges after subtracting the SMI deductible. Reasonable costs or charges were $109.36 per enrollee in 1967, and reimbursements were $62.40 per enrollee. Reasonable charges per aged enrollee rose 478 percent from 1967 to 1982; the SMI deductible rose only 50 percent in the same period (from $50 to $75 a year). Because the deductible became smaller in relation to reasonable charges, reimbursements as a percent of reasonable charges increased. In 1974 (the first full year of coverage for the disabled), Medicare reimbursed 67 percent of reasonable costs or charges to the disabled. Reasonable costs or charges were $173.38 per disabled enrollee, and reimbursements were $116.81 per enrollee. As derived from Table 3.15, by 1982, reasonable costs or charges for the aged and disabled combined had risen to $637 per enrollee, and reimbursements had risen to $469 per enrollee. Thus, in 1982, Medicare reimbursements under SMI increased to 74 percent of the reasonable costs or charges of all covered services for both aged and disabled enrollees.

As derived from the table, physicians' services for the aged and disabled combined made up the major share, 76 percent, of SMI reimbursements in 1982. Before October 1, 1982, inpatient radiology and pathology services were reimbursed at 100 percent of reasonable charges to physicians accepting assignment. The 1982 TEFRA changed payments for such services to 80 percent of the reasonable charges after the SMI deductible is met.

Table 3.15

Average reasonable charge and reimbursement per enrollee for supplementary medical insurance, by type of service and type of enrollee: Years ending June 30, 1967–82

Type of enrollee and year	Average enrollment	All services		Physicians' services[1]		Inpatient radiology and pathology services[2]		Outpatient services		Home health agency services		Health care prepayment plan services		Independent laboratory services	
		Reasonable cost or charge	Reimbursement	Reasonable charge	Reimbursement	Reasonable cost	Reimbursement	Reasonable cost	Reimbursement	Reasonable cost	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement
Aged	Number in thousands	Amount													
1967	17,750	$109.36	$62.40	$103.44	$59.02	NA	NA	$2.47	$1.41	$1.38	$0.79	$1.55	$0.88	$0.52	$0.30
1968	18,038	128.13	80.04	117.21	72.56	$1.89	$1.89	3.88	2.40	2.41	1.49	2.18	1.35	0.56	0.35
1969	18,833	145.58	93.72	126.11	79.06	6.57	6.57	6.74	4.23	3.06	1.92	2.46	1.54	0.64	0.40
1970	19,312	154.02	99.90	131.18	82.84	7.14	7.14	9.39	5.93	3.16	2.00	2.39	1.51	0.76	0.48
1971	19,664	162.57	106.26	137.72	87.80	7.21	7.21	11.86	7.56	2.63	1.68	2.20	1.40	0.95	0.61
1972	20,043	173.14	114.22	146.82	94.82	6.77	6.77	13.28	8.58	2.49	1.61	2.57	1.66	1.21	0.78
1973	20,428	186.57	122.38	157.43	100.95	6.99	6.99	14.74	9.45	3.01	2.17	2.93	1.88	1.47	0.94
1974	20,988	204.63	134.38	171.37	109.97	7.44	7.44	17.71	11.36	2.53	2.03	3.70	2.37	1.88	1.21
1975	21,504	237.09	160.23	193.13	127.48	8.72	8.72	23.45	15.48	4.65	3.84	4.65	3.07	2.49	1.64
1976	22,089	272.60	188.60	215.25	145.30	10.89	10.89	31.55	21.30	6.17	5.21	5.74	3.87	3.00	2.03
1977	22,605	313.92	221.34	242.45	167.00	12.21	12.21	41.69	28.72	7.59	6.54	6.38	4.39	3.60	2.48
1978	23,133	355.12	254.18	274.83	192.23	14.74	14.74	47.78	33.42	7.80	6.82	5.79	4.05	4.18	2.92
1979	23,693	397.07	287.46	304.62	215.83	16.33	16.33	56.87	40.29	7.75	6.86	6.83	4.84	4.67	3.31
1980	24,287	463.95	340.88	355.81	256.26	18.71	18.71	65.70	47.32	8.33	7.50	9.80	7.06	5.60	4.03
1981	24,826	543.44	404.66	413.40	301.87	22.94	22.94	78.28	57.16	8.98	8.20	12.51	9.14	7.33	5.35
1982	25,363	631.88	464.68	488.78	355.34	25.89	23.99	92.49	67.24	0.52	0.52	15.34	11.15	8.86	6.44
Disabled[3]															
1974	1,636	173.38	116.81	137.66	90.13	7.54	7.54	21.27	13.93	4.23	3.46	1.68	1.10	1.00	0.65
1975	1,813	215.00	149.71	172.54	117.41	8.40	8.40	25.52	17.37	4.22	3.59	2.76	1.88	1.56	1.06
1976	2,015	251.36	179.09	198.90	138.49	10.03	10.03	31.23	21.74	5.90	5.14	3.19	2.22	2.11	1.47
1977	2,229	305.07	220.58	228.79	161.85	13.03	13.03	51.60	36.50	5.42	4.79	3.40	2.41	2.83	2.00
1978	2,419	351.71	256.68	264.23	188.96	14.23	14.23	59.92	42.85	6.20	5.54	3.49	2.50	3.64	2.60
1979	2,560	408.02	301.47	308.75	223.79	17.08	17.08	69.32	50.25	5.66	5.13	2.82	2.04	4.39	3.18
1980	2,638	486.38	364.01	365.77	268.89	19.79	19.79	83.11	61.10	6.56	6.03	5.93	4.36	5.22	3.84
1981	2,683	574.08	433.85	425.26	315.92	23.00	23.00	104.60	77.71	7.84	7.28	7.06	5.24	6.32	4.70
1982	2,682	683.75	511.26	491.26	363.81	26.33	24.39	149.26	110.54	0.00	0.00	8.98	6.65	7.92	5.87

[1] Figures vary from those in Tables 3.16 and 3.17, as explained in the Note. Also, data in Tables 3.16 and 3.17 are for physicians' and other medical services; these data are for physicians' services only.
[2] These services were reimbursed under hospital insurance before April 1, 1968. Data shown are for April 1968 and later, and these charges are reimbursed at 100 percent.
[3] Excludes enrollees with end stage renal disease only.

NOTE: Figures vary from those in other tables in this report. These figures are actuarial estimates from a 0.1-percent sample of all aged enrollees and a 1.0-percent sample of all disabled enrollees. Reimbursements are estimated by subtracting deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceed amounts the program deems reasonable are excluded.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1984 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, Apr. 5, 1984.

The 1972 Social Security Amendments eliminated coinsurance payments for HHA services, and the 1980 Omnibus Budget Reconciliation Act eliminated the SMI deductible for these services. In 1982, HHA services were reimbursed at 100 percent of reasonable costs and were available to aged enrollees with only SMI coverage.

In Tables 3.16 and 3.17, data are provided on physicians' and other medical services used in 1982 by aged and disabled enrollees, respectively. The number of persons served per 1,000 enrollees was 3 percent higher for aged enrollees (636) than for disabled enrollees (618). However, reimbursement per person served was 31 percent higher for disabled enrollees ($828 versus $631). As a result, reimbursements per enrollee were 28 percent higher for disabled than aged enrollees.

For physicians' services, the number of persons served per 1,000 enrollees was higher for older age groups among both aged and disabled enrollees. Reimbursement per person served generally increased with age for aged enrollees; the reverse was true for disabled enrollees. Proportionately more women than men received benefits in both enrollee groups, although reimbursement per person served was 23 percent higher for aged men than for aged women. Among the disabled, average reimbursements per person served were similar for both sexes. The number of persons served per 1,000 enrollees was higher for white persons than for all other persons in both enrollment groups. Among the aged, reimbursement per person served was higher for white persons than for all other persons; the opposite was true among disabled persons served.

Data by region show that aged and disabled enrollees living in the West had the highest amount reimbursed per person served. Aged enrollees living in the North Central region had both the lowest rate of persons served per 1,000 enrollees and the lowest amount reimbursed per person served.

Data on total physicians' charges, reasonable charges as determined by carriers, and amounts reimbursed by Medicare in 1982 are shown in Table 3.18 for aged and disabled enrollees combined. The reduction in reasonable charges was 24 percent and varied little by region. The percent reduction was highest in the Northeast and lowest in the West. Medicare reimbursed 56.6 percent of physicians' charges after carriers made reasonable charge reductions and subtracted deductible and coinsurance amounts. The proportion of reimbursements to physicians' charges differed only slightly by region.

In Figure 3.1 is shown the distribution of total physicians' charges due (total charges less the reduction amount on assigned claims) between the amount paid by Medicare and the amount of beneficiary liability. In 1982, among aged persons served, Medicare reimbursed 64.9 percent of total physicians' charges due. The remainder, 35.1 percent, comprised the coinsurance (15.8 percent), the reduction on unassigned claims (13.1 percent), and the deductible (6.2 percent). It is also shown in Figure 3.1 that the proportion reimbursed for disabled persons served was 69.2 percent, somewhat higher than that of the aged.

Data on outpatient services provided to aged and disabled enrollees are presented in Tables 3.19 and 3.20. In 1982, reimbursements totaled $1,982 million for aged enrollees and $910 million for disabled enrollees. The disabled accounted for 31 percent of total reimbursements for outpatient services, although they represented 10 percent of all enrollees. The number of persons served per 1,000 enrollees was higher for disabled than for aged enrollees. Reimbursement per person served was 3.5 times greater for the disabled ($926) than for the aged ($265). By age, the highest amount reimbursed per person served was $1,397 for disabled enrollees under age 35. This large reimbursement reflects the relatively high proportion of disabled persons with end stage renal disease in this age group.

For outpatient services, the number of persons served per 1,000 aged enrollees was 6 percent greater for females, but males had a 15-percent greater reimbursement per person served. As a result, reimbursements per enrollee were 8 percent greater among males. Persons of races other than white had a user rate 7-percent higher than the rate for white persons and a 53-percent higher reimbursement per person served, resulting in a 64-percent higher reimbursement per enrollee for all other persons.

Data on outpatient service use among disabled enrollees show that females had both higher proportions using reimbursed services and higher reimbursements per person served than males. The combined effect was a 41-percent higher reimbursement per enrollee among disabled females than males. Differences were even more striking by race. A smaller proportion of white persons than all other persons used outpatient services, and white persons also had lower reimbursements per person served. This resulted in an average reimbursement per enrollee for all other persons that was 129 percent higher than that of white persons.

In Table 3.21, data are shown on covered hospital outpatient charges and reimbursements for aged and disabled enrollees (including those with ESRD) by census region in 1982. The proportions of charges reimbursed were 68.5 percent for aged enrollees and 73.2 percent for disabled enrollees. The amount reimbursed per enrollee was 221 percent greater for the disabled, primarily because most ESRD patients are included among the disabled. Reimbursements per enrollee were lowest in the South for both aged and disabled enrollees. They were highest in the West for the aged and in the Northeast for the disabled. The percent of charges reimbursed was highest in the West and lowest in the Northeast.

Financing

HI is financed primarily through a tax on a portion of current earnings in employment covered under the Social Security Act. Other sources of income for the program (shown in Table 3.22) include proceeds from the railroad retirement system, income to the trust fund

Table 3.16

Use of physicians' and other medical services by aged Medicare enrollees, by demographic characteristics: Calendar year 1982

Characteristic	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	25,706.8	16,345.7	635.9	$10,310.8	$630.79	$401.09
Age						
65–69 years	8,348.1	4,771.5	571.6	2,788.7	584.44	334.05
70–74 years	6,844.2	4,231.8	618.3	2,682.0	633.76	391.86
75–79 years	4,943.1	3,311.4	669.9	2,203.9	665.54	445.85
80–84 years	3,090.0	2,187.2	707.8	1,459.5	667.29	472.33
85 years or over	2,481.5	1,843.9	743.1	1,176.9	638.23	474.26
Sex						
Male	10,250.2	6,212.3	606.1	4,424.2	712.16	431.62
Female	15,456.6	10,133.4	655.6	5,886.7	580.91	380.85
Race[2]						
White	22,738.0	14,614.4	642.7	9,239.0	632.17	406.32
All other	2,230.7	1,279.8	573.7	796.8	622.64	357.21
Census region						
Northeast	6,056.2	4,071.2	672.2	2,597.0	637.89	428.81
North Central	6,741.6	4,114.3	610.3	2,372.8	576.71	351.96
South	8,327.0	5,168.2	620.7	3,169.0	613.16	380.57
West	4,334.6	2,903.9	669.9	2,129.3	733.24	491.24

[1] As of July 1, 1982.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.17

Use of physicians' and other medical services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1982

Characteristic	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,705.5	1,671.4	617.8	$1,384.5	$828.34	$511.74
Age						
Under 35 years	345.8	173.0	500.4	154.5	893.20	446.93
35–44 years	347.4	194.2	558.9	164.0	844.89	472.20
45–54 years	561.1	344.9	614.6	294.3	853.45	524.56
55–59 years	580.9	365.5	629.2	298.0	815.23	512.96
60–64 years	870.3	593.9	682.4	473.6	797.52	544.20
Sex						
Male	1,687.6	952.5	564.4	779.5	818.30	461.88
Female	1,017.9	718.9	706.2	605.0	841.64	594.41
Race[2]						
White	2,192.7	1,371.9	625.7	1,118.9	815.57	510.29
All other	458.7	267.6	583.3	239.1	893.62	521.22
Region						
Northeast	580.8	381.9	657.6	308.4	807.41	530.94
North Central	615.5	379.0	615.7	302.8	798.97	491.92
South	1,018.1	594.3	583.7	476.5	801.79	468.00
West	439.8	299.6	681.1	287.8	960.83	654.40

[1] As of July 1, 1982.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.18

Physicians' charges and Medicare reimbursements, by census region: Calendar year 1982

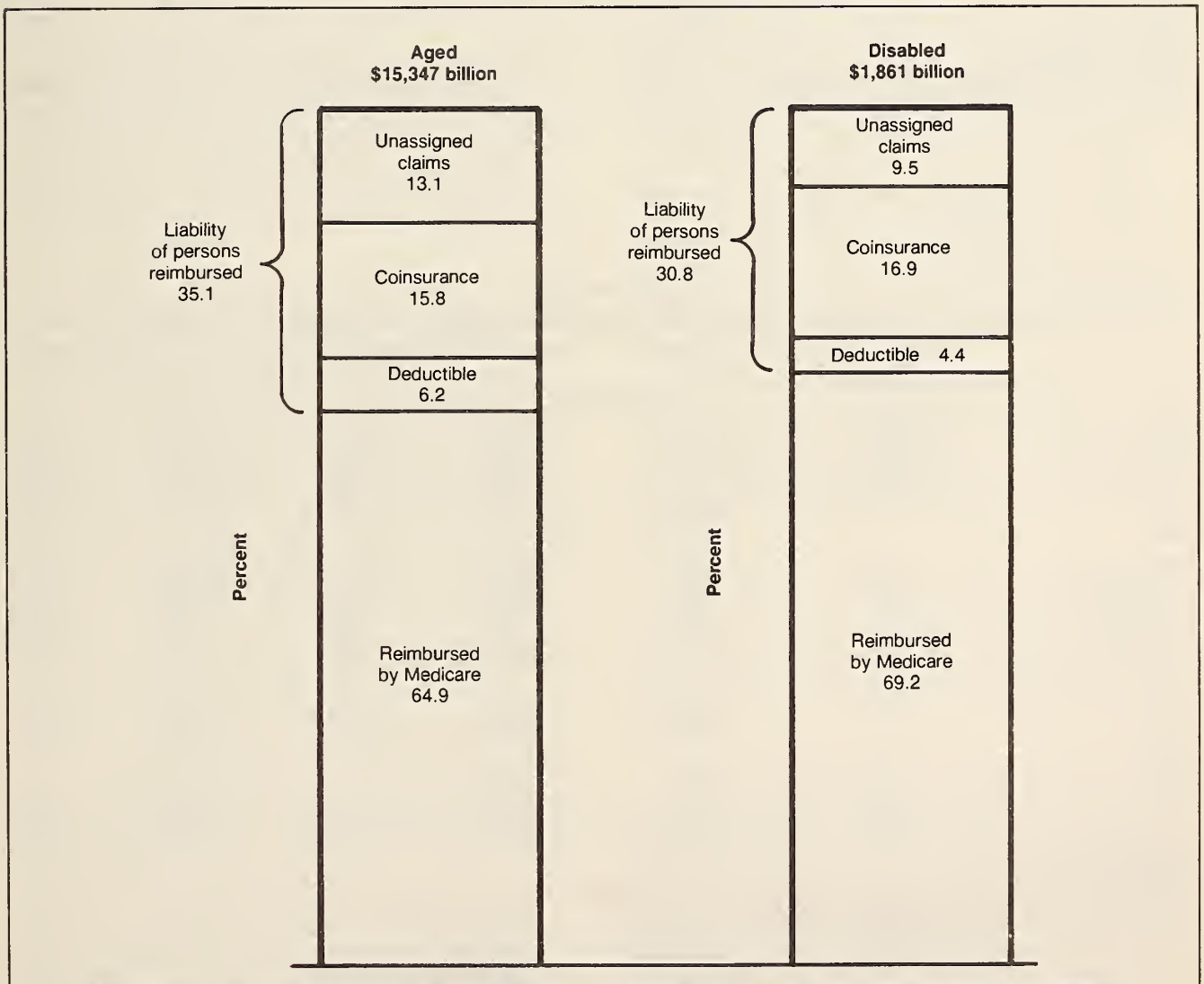
Census region	Charges		Percent reduction in total charges	Reimbursements	
	Total	Reasonable		Amount in millions	As percent of total charges
	Amount in millions				
United States[1]	$19,852	$15,017	24.4	$11,242	56.6
Northeast	5,058	3,753	25.8	2,808	55.5
North Central	4,318	3,285	23.9	2,445	56.6
South	6,361	4,809	24.4	3,606	56.7
West	4,103	3,161	23.0	2,375	57.9

[1] Includes unknown residence.

SOURCE: Health Care Financing Administraion, Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 3.1

Percent distribution of physicians' charges due for Medicare aged and disabled persons reimbursed: Calendar year 1982



SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Analysis.

Table 3.19

Use of outpatient services by aged Medicare enrollees, by age, sex, and race: Calendar year 1982

Age, sex, and race	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	25,706.8	7,465.1	290.4	$1,981.6	$265.45	$77.09
Age						
65–69 years	8,348.1	2,222.8	266.3	608.1	273.57	72.84
70–74 years	6,844.2	1,947.4	284.5	553.7	284.33	80.90
75–79 years	4,943.1	1,501.1	303.7	413.7	275.60	83.69
80–84 years	3,090.0	969.1	313.6	229.9	237.23	74.40
85 years or over	2,481.5	824.7	332.3	176.2	213.65	71.01
Sex						
Male	10,250.2	2,871.0	280.1	828.2	288.47	80.80
Female	15,456.6	4,594.2	297.2	1,153.6	251.10	74.64
Race[2]						
White	22,738.0	6,567.9	288.9	1,660.1	252.76	73.01
All other	2,230.7	692.4	310.4	267.0	385.62	119.69

[1] As of July 1, 1982.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.20

Use of outpatient services by disabled Medicare enrollees, by age, sex, and race: Calendar year 1982

Age, sex, and race	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,705.5	981.8	362.9	$909.5	$926.36	$336.16
Age						
Under 35 years	345.8	122.7	354.8	171.4	1,397.35	495.77
35–44 years	347.4	126.9	365.1	146.6	1,155.69	421.99
45–54 years	561.1	210.1	374.5	206.4	982.19	367.80
55–59 years	580.9	207.0	356.4	161.0	777.62	277.16
60–64 years	870.3	315.1	362.0	224.1	711.15	257.46
Sex						
Male	1,687.6	555.2	329.0	490.9	884.06	290.87
Female	1,017.9	426.5	419.0	418.6	981.42	411.23
Race[2]						
White	2,192.7	779.1	355.3	602.2	772.87	274.63
All other	458.7	184.9	403.0	288.6	1,560.83	629.06

[1] As of July 1, 1982.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1982.* HCFA Pub. No. 03189. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, Dec. 1984.

Table 3.21

Hospital outpatient charges and Medicare reimbursements, by type of enrollee and census region: Calendar year 1982

Census region	Covered charges in millions		Reimbursements					
			Amount in millions		Per enrollee		As percent of covered charges	
	Aged	Disabled	Aged	Disabled	Aged	Disabled	Aged	Disabled
All areas	$2,402.4	$759.6	$1,645.0	$556.3	$63.99	$205.62	68.5	73.2
United States	2,395.6	756.1	1,641.0	553.8	64.41	208.41	68.5	73.2
Northeast	718.2	220.0	462.0	154.7	76.29	266.35	64.3	70.3
North Central	635.1	212.7	437.3	159.5	64.87	259.14	68.9	75.0
South	555.9	185.7	384.1	135.3	46.13	132.89	69.1	72.9
West	485.5	137.6	356.9	104.3	82.34	237.14	73.5	75.8

NOTE: Includes enrollees with end stage renal disease.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Data from the Division of Information Analysis.

appropriated from general revenues to reimburse the program for costs of uninsured enrollees, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses.

In 1982, payroll taxes accounted for 91 percent of the HI trust fund's total income. The share of total income from payroll taxes has remained at about this level for the last several years. In the 1960's, the payroll tax share fluctuated from a high of 95.6 percent in 1966 to a low of 77.9 percent in 1968. Since 1968, benefit payments have accounted for 97 percent or more of all HI disbursements.

The Federal SMI trust funds (Table 3.23) come from premiums paid by or on behalf of SMI enrollees, contributions of the Federal Government from the general fund of the Treasury, and interest from investments of the fund. At the start of Medicare, the monthly SMI premium was $3. As of January 1, 1987, the premium had risen to $17.90 per month. Until 1973, premiums were set to finance one-half of the benefit and administrative costs of the SMI program plus a contingency amount. General revenues financed the other half. The 1972 amendments altered that arrangement. Beginning July 1973, monthly premiums could be raised only if monthly social security cash benefits were increased. Furthermore, premiums were permitted to rise no more than the percentage increase in cash benefits. The Social Security Amendments of 1983 changed the premium adjustment period from a 12-month period ending June 1983 to one ending December 1983. Therefore, premium adjustments are now made for a calendar year. The Part B premium was set at 25 percent of the expected average cost for aged enrollees for January 1984 through December 1985, and DEFRA of 1984 extended this provision through 1987.

Since the 1972 Social Security Amendments, the major source of income for the SMI trust fund has been Federal Government contributions, which made up 74 percent of total income in 1982. Enrollees' premiums made up 22 percent, and the remainder was interest on investments.

Administration

HI intermediaries

Under HI, groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their intermediary. Under an agreement with the Secretary of DHHS, the intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. Under the agreement, the intermediary may also furnish consultative services to assist providers in establishing and maintaining the fiscal records needed to qualify as providers of service; serve as a center for communicating with providers; or audit provider records. HI intermediaries also make payments for home health and outpatient hospital services covered by SMI.

Reasonable costs of services are determined by regulations of the Secretary of DHHS. Charges for covered services generally are submitted by the provider, who is reimbursed for reasonable costs of covered services less the deductible and coinsurance amounts. The beneficiary pays these amounts and also pays for noncovered services.

The provider's intermediary reviews claims for payment and pays the provider. Payments for claims are made on the basis of interim rates established by both the provider and the intermediary. Final settlement for each provider's operating year is based on the provider's cost report and is subject to an independent audit.

Medicare's retrospective cost-based system continues to apply to SNF's and HHA's but not to most hospitals. Under the prospective payment system (PPS), which began October 1983, most hospitals providing inpatient services to Medicare enrollees are no longer paid on a reasonable-cost basis. Under PPS, the intermediary assigns the appropriate diagnosis-related group code to each patient bill record and then pays the hospital a predetermined fixed rate for each discharge according to the DRG. In general, PPS payments for a given case are considered full payment except for deductible and coinsurance amounts.

Table 3.22

Operations of the Medicare hospital insurance trust fund: Calendar years 1966–82

Year	Income							Disbursements			Trust fund	
	Total income	Payroll taxes	Transfers from railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Interest on investment	Total disbursements	Benefit payments	Administrative expenses	Net change in fund	Fund at end of year
	Amount in millions											
1966	$1,943	$1,858	$16	$26	NA	$11	$32	$999	$891	$108	$+944	$944
1967	3,559	3,152	44	301	NA	11	51	3,430	3,353	77	+129	1,073
1968	5,287	4,116	54	1,022	NA	22	74	4,277	4,179	99	+1,010	2,083
1969	5,279	4,473	64	617	NA	11	113	4,857	4,739	118	+422	2,505
1970	5,979	4,881	66	863	NA	11	158	5,281	5,124	157	+698	3,202
1971	5,732	4,921	66	503	NA	48	193	5,900	5,751	150	−168	3,034
1972	6,403	5,731	63	381	NA	48	180	6,503	6,318	185	−99	2,935
1973	10,821	9,944	99	451	$2	48	278	7,289	7,057	232	+3,532	6,467
1974	12,024	10,844	132	471	5	48	523	9,372	9,099	272	+3,652	9,119
1975	12,980	11,502	138	621	7	48	664	11,581	11,315	266	+1,399	10,517
1976	13,766	12,727	143	[1]0	9	141	746	13,679	13,340	339	+88	10,605
1977	15,856	14,114	[2]0	[1]803	12	[3]143	784	16,019	15,737	283	−163	10,442
1978	19,213	17,324	[2]214	688	13	141	834	18,178	17,682	496	+1,035	11,477
1979	22,825	20,768	191	734	16	141	975	21,073	20,623	450	+1,751	13,228
1980	26,097	23,848	244	697	18	141	1,149	25,577	25,064	512	+521	13,749
1981	35,725	32,959	276	659	22	207	1,603	30,726	30,342	384	+4,999	18,748
1982	38,034	34,586	351	808	24	207	2,058	36,144	35,631	513	[4] −10,548	8,200

[1] No transfer was made for 1976 because of the change in transfer dates from December to March. The 1977 transfer was for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

[2] No transfer was made in 1977 because of a change in the transfer dates from August to June. The 1978 transfer is for contributions during the 5-quarter period covering the transition quarter and fiscal year 1977.

[3] Includes $2 million in reimbursement from general revenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

[4] A loan of $12,437 million to the Old Age and Survivors' Insurance (OASI) trust fund is still an asset of the hospital insurance (HI) trust fund. However, because these assets are not immediately available for payment of HI benefits, they are subtracted from the HI fund at the end of the year. The 1982 negative amount is a loan to the OASI trust fund.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund: *1984 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.* Washington. U.S. Government Printing Office, Apr. 5, 1984.

Table 3.23

Operations of the Medicare supplementary medical insurance trust fund: Calendar years 1966–82

Year	Income				Disbursements			Trust fund	
	Total income	Premiums from enrollees	Government contributions[1]	Interest on investments	Total disbursements	Benefit payments	Administrative expenses	Net change in fund	Fund at end of year
	Amount in millions								
1966	$324	$322	$0	$2	$203	$128	$75	$+122	$122
1967	1,597	640	933	24	1,307	1,197	110	+290	412
1968	1,711	832	858	21	1,702	1,518	184	+9	421
1969	1,839	914	907	18	2,061	1,865	196	−222	199
1970	2,201	1,096	1,093	12	2,212	1,975	237	−11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	+262	450
1972	2,808	1,382	1,389	37	2,614	2,325	289	+193	643
1973	3,312	1,550	1,705	57	2,844	2,526	318	+468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	+395	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	−62	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	+355	1,799
1977	7,805	2,247	5,386	172	6,505	6,038	467	+1,300	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	+1,301	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	+502	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	−372	4,530
1981	15,374	3,722	11,291	361	14,028	13,113	915	+1,347	5,877
1982	16,580	3,697	12,284	599	16,227	15,455	772	+353	6,230

[1] Payments from the general fund of the U.S. Treasury include certain interest-adjustment items.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1984 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U.S. Government Printing Office, Apr. 5, 1984.

Table 3.24

Medicare hospital insurance intermediaries—workload and cost data: Fiscal years 1975–82

Year	Bills processed		Total administrative cost		Total unit cost		Revised administrative cost		Unit cost excluding audit		Provider audit and reimbursement cost	
	Number in thousands	Index	Amount in millions	Index	Amount	Index	Amount in millions	Index	Amount	Index	Amount in millions	Index
1975	25,723.4	100.0	$151.8	100.0	$5.90	100.0	$121.5	100.0	$4.72	100.0	$36.8	100.0
1976	25,898.7	112.3	164.8	108.6	5.70	96.6	133.0	109.4	4.60	97.5	39.7	107.8
1977	32,119.0	124.1	182.3	120.1	5.68	96.3	146.8	120.8	4.57	96.8	44.1	120.0
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	141.8	116.7	4.07	86.2	47.7	129.6
1979	36,410.1	141.5	201.5	132.8	5.54	93.9	147.4	121.3	4.05	85.8	52.0	141.3
1980	39,789.3	154.7	216.0	142.3	5.43	92.0	155.1	127.7	3.90	82.6	60.9	165.5
1981	42,539.8	165.4	234.6	154.5	5.52	93.6	166.2	136.7	3.91	82.8	68.4	185.9
1982	42,292.2	164.4	220.6	145.3	5.21	88.3	154.3	127.0	3.65	77.3	66.1	179.6

SOURCES: Health Care Financing Administration: *Medicare Annual Report, Fiscal Year 1981.* HCFA Pub. No. 02156. Washington. U.S. Government Printing Office, 1984; Health Care Financing Administration: Data from the Bureau of Program Operations.

Table 3.25

Medicare supplementary medical insurance carriers—workload and cost data: Fiscal years 1975–82

Year	Claims processed		Total administrative cost		Claims unit cost		Payment records processed		Payment records unit cost	
	Number in thousands	Index	Amount in millions	Index	Amount	Index	Number in thousands	Index	Amount	Index
1975	80,613.7	100.0	$258.7	100.0	$3.21	100.0	63,837.4	100.0	$4.05	100.0
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	75,266.1	117.9	3.86	95.3
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	88,983.8	139.4	3.63	89.6
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	100,087.3	156.8	3.43	84.7
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	112,864.6	176.8	3.32	82.0
1980	152,312.6	188.9	398.0	153.8	2.61	81.3	129,465.8	202.8	3.07	75.8
1981	169,541.7	210.3	450.5	174.1	2.66	82.9	146,992.6	230.3	3.07	75.8
1982	174,901.8	217.0	439.0	169.7	2.51	78.2	149,598.1	234.3	2.93	72.3

SOURCES: Health Care Financing Administration: *Medicare Annual Report, Fiscal Year 1981.* HCFA Pub. No. 02156, 1984; Health Care Financing Administration: Data from the Bureau of Program Operations.

In Table 3.24, workload and cost data for HI intermediaries are summarized for the period 1975–82. Although the number of bills processed increased 64.4 percent during that period, administrative costs increased by only 45.3 percent.

SMI carriers

The Secretary of DHHS contracts with carriers to perform certain administrative duties under SMI. Carriers compute reasonable charges, make payments, determine whether claims are for covered services, deny claims for noncovered services, and deny claims for unnecessary use of services. Workload and cost data for SMI carriers are presented in Table 3.25.

Claims for SMI benefits may be submitted to the carrier by the patient or by the provider. Patients who submit claims (itemized bills) directly to the carrier receive direct payment for covered services but remain responsible for the physician's (or supplier's) bill.

A physician or other supplier of services may accept assignment, accepting the reasonable charge as determined by the carrier as the total charge. The physician (or supplier) submits the bill, and the carrier reimburses 80 percent of the reasonable charge. The patient is then responsible for the remaining 20 percent of the allowed charge and for any deductible.

Prepaid health plans

Health care prepayment plans (HCPP's)[6] and health maintenance organizations (HMO's) are prepaid health plans that render physicians' services and other health care services to voluntarily enrolled subscribers in return for predetermined premium payments. This differs from the more common method of payment on a per visit or per service basis.

Prepaid health plans that provide services to Medicare enrollees have several options for participation in Medicare. They may contract to deal directly with Medicare either under Section 1833 of the Social Security Act as health care prepayment plans or under Section 1876 as health maintenance organizations. HMO's may contract on a cost-reimbursement basis or on a risk basis. HMO's that do not contract directly with Medicare are "carrier dealing" plans, billing and receiving reimbursement through the regular Medicare fee-for-service billing procedures. In all cases, Medicare beneficiaries pay the plan (or have paid on their behalf through employment or retirement benefits) a supplementary premium to cover the Medicare deductible and coinsurance and any benefits or services provided by the plan but not covered by Medicare.

The number of contracting HCPP's and HMO's and their Medicare members are shown by size of Medicare membership in Table 3.26. As of March 1984, the 128 contracting prepaid health plans had a total of 859,456 Medicare members, about 3 percent of the total Medicare population. The five largest plans—all but one of them contracting as HCPP's—accounted for 58 percent of all Medicare members of prepaid health plans.

Health care prepayment plans

Section 1833 was written into the original Medicare legislation to enable HCPP's to participate in Medicare with minimal constraints. HCPP's are paid monthly interim payments for SMI physicians' and related services based on estimated allowed costs per Medicare beneficiary and the number of Medicare member-months covered. At the end of the fiscal year, a postaudit adjustment is made based on the portion of audited physician and related costs allocated to Medicare

[6] Medicare regulations in 1983 changed the name from group practice prepayment plans to health care prepayment plans.

Table 3.26

Number of health care prepayment plans and health maintenance organizations participating in Medicare and number of Medicare members, by size of Medicare membership: March 1984

Size of Medicare membership	Total		HCPP's[1]		HMO's[2]	
	Plans	Medicare members	Plans	Medicare members	Plans	Medicare members
All sizes	[3]128	859,456	44	577,753	84	281,703
Less than 100	12	502	1	23	11	479
100–499	18	5,278	6	1,850	12	3,428
500–999	20	15,153	5	3,601	15	11,552
1,000–4,999	52	116,377	18	42,478	34	73,899
5,000–9,999	15	115,212	6	48,397	9	66,815
10,000–19,999	4	55,375	4	55,375	0	0
20,000–49,999	2	54,708	0	0	2	54,708
50,000–99,999	2	150,810	1	79,988	1	70,822
100,000 or more	3	346,041	3	346,041	0	0

[1] Health care prepayment plans.
[2] Health maintenance organizations.
[3] The Portland Kaiser Plan is counted twice because it has an HMO demonstration contract for 7,823 Medicare members and an HCPP contract for 16,192 Medicare members.

SOURCE: Health Care Financing Administration, Office of Prepaid Health Care: Data from the Division of Methods and Procedures.

members. Other Medicare-covered services provided by the plan are billed on the basis of charges related to costs through the routine Medicare billing procedures (that is, through carriers and intermediaries). These services may include HI hospital, skilled nursing facility, and home health agency services.

Section 1833 contracts cover a wide variety of plans, including some of the oldest and largest plans in the country. In comprehensiveness of service, HCPP's vary from little more than ambulatory primary care to a full range of services, including dental care, eye care, inpatient hospital and SNF care, and home health services. Several HCPP's own or operate their own hospitals, SNF's, and HHA's. Medicare members of HCPP's may also use out-of-plan services and receive Medicare reimbursement for them. This provision allows Medicare members of HCPP's that do not provide comprehensive Medicare-covered services to receive full Medicare benefits. Reimbursement for out-of-plan services is through the routine Medicare billing process.

Health maintenance organizations

The favorable cost experience of a few HCPP's led to the Federal policy of encouraging this form of delivery and payment for Medicare beneficiaries. In 1972, Section 1876 was added to the Medicare law to specify how and under what conditions HMO's may contract with Medicare. To encourage HMO's to enroll Medicare beneficiaries, the law gives them the opportunity to share in cost savings resulting from efficient management and use of resources by entering into risk-basis contracts. If they do not choose this option or cannot meet the specifications for risk contracting, they may enter into cost-basis contracts.

Two major requirements of a contracting HMO are: certification as federally qualified by the Office of Prepaid Health Care, HCFA, and availability to its Medicare enrollees, either directly or under contractual arrangements with area providers, of all Medicare-covered services normally available to fee-for-service Medicare beneficiaries in its service area. (Developing HMO's are given 3 years to meet the latter requirement.) Thus, requirements for HMO's are considerably more stringent and restrictive than those for HCPP's. A plan that operates as an HMO for its general membership but has not contracted with HCFA to serve Medicare enrollees as an HMO is classified as an HCPP in Table 3.26. As of March 1984, 84 HMO's with a total of 282,000 Medicare members operated under Section 1876 contracts.

Cost-contracting HMO's function much like HCPP's in relation to Medicare. They receive monthly interim payments during the year based on their estimated allowed costs, with a postaudit adjustment to actual allowed costs at the close of the year, and their Medicare members may use and receive Medicare reimbursement for out-of-plan services. A major difference is that HMO payments may include all HI and SMI services, as noted earlier, whereas HCPP payments are limited to SMI physicians' and related medical services only, even if the HCPP provides other Medicare-covered services to its Medicare members.

Section 1876 risk-contracting HMO's receive interim payments during the year. However, in the postaudit adjustment, each risk-contracting HMO's savings or losses are determined by comparing its audited allowed costs per Medicare member with the adjusted average per capita cost (AAPCC) for its service area. The AAPCC is computed by applying a geographic index specific to the HMO's service area to the average per capita costs for all Medicare beneficiaries, then further adjusting for characteristics of the HMO's Medicare membership, including age, sex, institutionalized status, and welfare status. Separate HI and SMI AAPCC's are calculated for Medicare aged and disabled beneficiaries. If the risk-contracting HMO's costs are higher than its AAPCC, it must absorb the loss or carry it over to be offset by future savings. If costs are less than the AAPCC, the HMO shares the "savings" with the Medicare program. An HMO may reserve savings of up to 10 percent of the AAPCC.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) authorized prospective reimbursement under risk contracts with HMO's and other eligible organizations at a rate equal to 95 percent of the AAPCC. This provision took effect in January 1985. The number of HMO's with Medicare contracts is expected to increase significantly.

A major difference between risk HMO's and other contracting plans is that Medicare members of a risk HMO are "locked in" to the plan's services; that is, they cannot choose to use out-of-plan services and receive Medicare reimbursement for them. (Exceptions are emergency service and "urgently needed" out-of-area services.) Thus, risk-contracting HMO's must make all Medicare-covered services available to Medicare members.

Section 114 of the 1982 TEFRA expanded the definition of prepaid health organization eligible to contract with Medicare to provide medical services. Regulations implementing Section 114 became effective in February 1985. New organizations called competitive medical plans provide both HI and SMI services for a fixed prepaid fee and, if they meet specific qualifying requirements, are eligible to contract for Medicare reimbursement. TEFRA permits payment on a prepaid capitated basis without either retroactive payments or the detailed costfinding procedures of earlier cost- and risk-contracting options.

Medicare statistical system

The Medicare statistical system provides data for analyzing and evaluating the program's effectiveness. The system consists of four major computer files: the health insurance master, the provider of service, the HI claims, and the SMI payment records files.

The health insurance master file contains records for each aged and disabled enrollee and includes data on the enrollee's type of entitlement, deductible status, benefit period status, and benefits used. This file

provides population data for the program and is the base used in computing a variety of user rates by age, sex, race, and residence.

The provider of service file contains information on hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, and suppliers of portable X-ray or outpatient physical therapy services that participate in Medicare. This file consists of data from the provider application-for-participation forms. For hospitals, it includes data on the number of beds, type of ownership, and other characteristics. Provider data are updated regularly.

The HI claims file contains information on beneficiaries' entitlement and the extent to which enrollees have used covered benefits. When an enrollee uses a participating medical facility (for example, a hospital or skilled nursing facility), admission and billing forms are forwarded to HCFA's Central Office. In this office, all "benefit period" information needed by carriers is recorded. Information on stays in certain nonparticipating institutions and days of care not covered or reimbursable under the program is included. The admission and billing form contains both a Medicare enrollee identification number and a provider number. A computer tape record of this form, when matched with enrollee entitlement and provider tapes, forms a statistical research tape. The resulting tape provides enrollee, provider, use-of-service, and cost data for each enrollee. As part of the data sampling process, information on diagnoses and surgical procedures is obtained for a 20-percent sample of hospitalized enrollees.

The HCFA central SMI payment records file is used to inform carriers whether or not enrollees have met the deductible. It also provides information on amounts paid by carriers for physicians' services and for other SMI-covered services and supplies. A bill summary file is derived from a sample of the SMI payment records file for statistical research.

To better meet Medicare's data needs on physicians' reimbursements, the following four files are generated from all SMI carrier service data.

- A procedure file contains complete counts of all physician medical procedures, medical supplies, amounts charged, and amounts paid. This file provides complete information on Medicare physician and supplier services.
- A prevailing charge file provides prevailing charge information for each service in the procedure file. This allows HCFA to study and forecast payment levels more accurately.
- A provider file contains data from submitted claims on all services rendered by a sample of physicians and suppliers. This allows study of the effect of program changes on physicians' service practices and permits longitudinal analysis of these practices.
- A beneficiary file provides a complete record, from submitted claims, of services received by a sample of beneficiaries. This permits linkage of information on beneficiary use of physicians' and suppliers' services to already existing files containing data on the use of HI services.

These four files supplement data currently available and have been prepared annually beginning with 1983. These files are used by numerous bureaus and offices in HCFA. For the Office of Research and Demonstrations, for example, they are useful for providing data and analysis on specific procedures, physician practices, and patient episodes.

The Medicare statistical system enables HCFA to prepare a wide variety of research studies on the use of and reimbursement for Medicare services. Data from the system provide information about enrollee use of benefits for a point in time or over an extended period. Statistical reports are produced on enrollment, characteristics of participating providers, reimbursements, and services used.

Medicare also has implemented the Continuous Medicare History Sample (CMHS) beginning with 1974 data. CMHS provides longitudinal data on Medicare program use by a sample of enrollees. The CMHS files consist of data from all of the Medicare user files for a number of years. Selected data from the enrollment and user files have been combined into one record for each sample person to acquire specific person data.

CMHS is a 5-percent probability sample of Medicare health insurance claim numbers. New enrollees whose claim numbers place them in CMHS are added to the sample, and the records for enrollees whose Medicare coverage ends are retained in the file. The ability to link different data files over a period of years is a key feature of CMHS and the Medicare statistical system. It permits detailed analysis of specific groups of enrollees over time.

4. Medicaid: Description and data

Detailed information on the Medicaid program, including eligibility criteria, recipient characteristics, benefit coverage, service use, expenditures, financing, and administration, are presented in this chapter.[7] Explanations of program requirements are based on regulations contained in title 42 of the U.S. *Code of Federal Regulations* (CFR), parts 430–456.

First, information is given on Federal requirements and State options in defining the eligibility of the categorically and medically needy. Data are presented on the distribution of recipients by State, eligibility category, age, and sex. Medicaid benefits offered by each State, including optional services, benefit limitations, and cost-sharing requirements, are described. Data on the use of Medicaid-covered services are also presented, including data for each State on the distribution of recipients, number of recipients, and total volume of services by type of service.

The next focus is Medicaid expenditures. The distribution of State expenditures is shown by eligibility category, age, and sex of recipients and by type of service. Comparisons of average expenditures per recipient by State and ratios of Medicaid recipients to persons at or below the poverty level are also presented. A description of Medicaid financing, including information on matching rates for Federal financial participation, follows.

Various topics concerning Medicaid administration, including provider reimbursement methods, expenditures for administrative training, numbers of certified providers, administrative responsibility for eligibility determination, and adoption of management information systems, are discussed. For the first time, an evaluation of the cost of the first 2 years of the Arizona Health Care Cost Containment System is included. It is followed by a description of the Medicaid data system. The chapter concludes with a summary of selected changes to Medicaid brought about by the Deficit Reduction Act of 1984 (DEFRA).

Eligibility

Medicaid is a major component of the current public assistance system, and its eligibility provisions are among the most complex of all assistance programs. At a minimum, States must cover all persons who receive cash payments from the Aid to Families with Dependent Children (AFDC) program and almost all persons covered by the Supplemental Security Income (SSI) program. These persons are called the categorically needy. States have the option of extending Medicaid coverage to the medically needy and to specified groups of people known as the optionally categorically needy. The medically needy are categorically related individuals who are ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficient to meet their medical needs. In this section, the standards States use to determine who is eligible for Medicaid are described.

Categorically needy

As shown in Figure 4.1, the categorically needy include AFDC and SSI cash assistance recipients and may also include optional groups related to each cash assistance category. A discussion of the AFDC and SSI categories follows.

Aid to Families with Dependent Children

The Federal Government offers States a number of options for Medicaid coverage through AFDC programs. State Medicaid programs must cover all persons receiving cash assistance under the State's AFDC plan and families terminated from cash assistance because of increased earnings or hours of employment. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA–81), States also were required to provide Medicaid coverage to qualifying persons under age 21 who met age or school attendance requirements for AFDC. Section 2172 of OBRA–81 dropped this requirement, making coverage of such individuals a State option. States may now limit such coverage to children under age 21, 20, 19, 18, or any other reasonable age cutoff. At State option, the AFDC State plan may include families with unemployed parents, pregnant women with no other eligible children, and children age 18 who are regularly attending school. If the State extends AFDC coverage to these groups, it must extend Medicaid coverage as well.

Prior to OBRA–81, each State had the option of extending AFDC eligibility to children age 18–20 years who were regularly attending school, college, or university or a course of vocational or technical training. As of October 1, 1981, this optional coverage is restricted to 18-year-olds who are full-time students in secondary school or the equivalent level of vocational or technical training and who can reasonably be expected to complete the program before reaching their 19th birthday.

Before October 1, 1981, States had the option under their AFDC program of extending Medicaid coverage to "unborn children." The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 provided coverage directly to pregnant women. TEFRA also extended direct coverage to "unborn children," previously covered on a temporary basis under 42 CFR 435.222.

At State discretion, a Medicaid program can extend benefits to certain "AFDC-related" groups. Prior to the enactment of OBRA–81, States also could extend

[7] The numbers presented in the tables may differ from those in previous publications, including those found in former editions of the Data Book. These differences resulted mainly from late reports received by the Health Care Financing Administration and resulting adjustments.

Figure 4.1

Eligibility coverage of the categorically needy: March 31, 1984

Eligibility criteria for the categorically needy:

- Aged, blind, disabled or member of family unit deprived of support of parent
- Income standard
- Resource standard

AFDC populations for which coverage is:

Mandatory

- Individuals receiving AFDC payments (42 CFR 435.110)
- Families terminated from AFDC because of increased earnings or hours of employment (42 CFR 435.112)
- Individuals ineligible for AFDC because of requirements that do not apply under Title XIX of the Social Security Act (42 CFR 435.113)
- Individuals who would be eligible for AFDC except for increased OASDI income under Public Law 92–336 of July 1, 1972 (42 CFR 435.114)
- Deemed recipients of AFDC (42 CFR 435.115)
- Children for whom adoption assistance or foster care maintenance payments are made under Title IV–E of the Social Security Act (42 CFR 435.118)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220)
- Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children (42 CFR 435.222)
- Individuals who would be eligible if coverage under State's AFDC plan were as broad as allowed under Title IV–A of the Social Security Act (42 CFR 435.223)

SSI populations for which coverage is:

Mandatory

- Individuals receiving SSI payments (42 CFR 435.120)
- Individuals in States using more restrictive requirements for Medicaid than SSI (42 CFR 435.121)
- Individuals ineligible because of requirements that do not apply under Medicaid (42 CFR 435.122)
- Individuals receiving mandatory State supplements (42 CFR 435.130)
- Individuals who were eligible for Medicaid as an essential spouse in Dec. 1973 and have continued to live with and be essential to the well-being of a recipient of cash assistance (42 CFR 435.131)
- Institutionalized individuals eligible in Dec. 1973 (42 CFR 435.132)
- Blind and disabled individuals eligible in Dec. 1973 (42 CFR 435.133)
- Individuals who would be eligible except for increased OASDI benefits under Public Law 92–336 of July 1, 1972 (42 CFR 435.134)
- Individuals who: (a) become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977; (b) would still be eligible for SSI or SSP if that increase were deducted from income (42 CFR 435.135)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220)
- Individuals receiving only optional State supplements (42 CFR 435.230)
- Individuals in institutions who are eligible under a special income level (42 CFR 435.231)
- Individuals receiving home and community-based services who are eligible under a special income level (42 CFR 435.232)
- Certain disabled children age 18 or under who live at home and would be eligible if in a medical institution (1902(e)(3) of the Social Security Act, Public Law 97–248, section 134)

NOTES: AFDC = Aid to Families with Dependent Children. SSI = Supplemental Security Income.
OASDI = Old Age, Survivors, and Disability Insurance. SSP = State Supplemental Payments.
CFR = *Code of Federal Regulations.*

SOURCE: *Code of Federal Regulations*: Public Health, Title 42, Chapter IV. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office.

coverage to another optionally categorically needy group known as "caretaker relatives." Further information can be found in 42 CFR, part 435, effective October 1, 1980. The optional categorically needy groups are listed in the order in which they appear in Table 4.1:

- Individuals under age 21 (or at State option, under age 20, 19, or 18) who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program. States may limit coverage to certain groups, such as children in foster homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities (42 CFR 435.222).
- Individuals who are eligible for but not receiving cash assistance (42 CFR 435.210).
- Individuals who would be eligible for AFDC cash assistance if they were not institutionalized (42 CFR 435.211).
- Individuals who would be eligible for AFDC payments if the State AFDC program were as broad as Title IV-A of the Social Security Act allows (42 CFR 435.223).
- Individuals who would be eligible for AFDC payments if child care costs were paid from earnings (42 CFR 435.220).

Income standards for cash assistance and Medicaid eligibility are set by the States. Data for 1984 on the annual AFDC need and payment standards used by States to determine Medicaid eligibility for AFDC recipients and, for States with such a program, the medically needy are shown in Table 4.2. Eligibility standards for the medically needy are discussed later. Data are shown for two-person and four-person families. Data for other family sizes are available from State public assistance plans.

The need standard is the amount of money a State determines essential to meet a minimal standard of living in that State for a specified family size. In general, the standard provides for basic consumption items, such as food, clothing, shelter, fuel and utilities, personal care items, household items, and in certain cases, special or recurrent needs. Some States vary the need standard to reflect differences in actual costs within the State, others vary it by season, and one varies it according to the age of the child.

In addition to the need standard, States set the standard of payment for AFDC families. Payment standards vary widely, from a high of $9,300 in Alaska to a low of $1,728 in Tennessee for four-person families. (Program data for the four territories of Guam, the Northern Marianas, Puerto Rico, and the Virgin Islands are not included in Table 4.2.) For most States, the payment standard is the maximum amount of cash assistance paid to a family with no countable income. Approximately 60 percent of the States set a payment standard that is lower than the need standard. It should be noted, however, that these States may provide a substantially higher level of assistance than States meeting full need under a relatively low standard.

Supplemental Security Income

Prior to 1974, States had the same authority to set cash assistance and Medicaid eligibility standards for the aged, blind, and disabled as they had for the AFDC population. Since 1974, however, the Federal SSI program has included minimum income standards for cash assistance to the aged, blind, and disabled. Since the SSI program began, States have been permitted to choose one of three ways to determine Medicaid eligibility for these persons. The Medicaid program could cover all SSI recipients or all persons receiving an SSI benefit or State supplementary payment, including their eligible spouses. A State Medicaid program could also cover all persons who met the eligibility criteria for medical assistance in effect on January 1, 1972, or some less restrictive criteria. These criteria had to be more restrictive than the criteria for SSI benefits or State supplements, and they had to be applied to the individual's income after subtracting his or her SSI benefit, optional State supplements, and incurred medical expenses. States taking this option are known as "209(b)" States, and this deduction is referred to as the "209(b) spend-down."

States were also required to provide Medicaid coverage to the following groups that were eligible for Medicaid in December 1973:

- Individuals receiving a mandatory State supplementary payment (42 CFR 435.130).
- Essential spouses (42 CFR 435.131).
- Institutionalized individuals (42 CFR 435.132).
- Blind and disabled individuals (42 CFR 435.133).

These requirements were established to prevent loss of eligibility for cash assistance recipients in transition to SSI from the former Federal-State assistance programs. Individuals could have lost eligibility if States narrowed their definitions of disability or visual impairment. To prevent this, in December 1973, recipients of Aid to the Blind and Aid to the Permanently and Totally Disabled were deemed to meet the SSI criteria for blindness or disability in States with more liberal categorical definitions. Individuals also could have lost their eligibility if SSI used lower income and resource levels than their State had previously employed. Therefore, States with more liberal financial standards were required to pay the difference between the lower SSI benefit and the individual's previous cash benefit and to extend Medicaid benefits to such individuals. This requirement is called mandatory supplementation. Although the mandatory supplement comes out of State revenues, it may be administered by the Federal Government at State option.

To protect individuals in States choosing not to extend Medicaid coverage to all SSI recipients, the law required that all 209(b) States adopt a "spend-down" for Medicaid. In determining eligibility for Medicaid assistance, 209(b) States must exclude from the applicant's income: the SSI payment, any optional State supplement an individual receives, and any medical expenses incurred by the individual. This 209(b), or

Table 4.1

Medicaid coverage under Aid to Families with Dependent Children, by jurisdiction: March 1984

Medicaid jurisdiction	Included in AFDC[1] State plan			Optional categorically needy				
						Persons who would be eligible		
	Families with unemployed parents	Pregnant women with no eligible children	Children age 18 regularly attending school	Financially eligible persons under age 21	Persons eligible for but not receiving aid	Except for institutional status	If State plan were as broad as Social Security Act allows	If child care costs were paid from earnings
Alabama		X		X		X		
Alaska		X		X	X	X		
Arkansas				X		X		
California	X	X	X	X	X	X		X
Colorado	X	X	X			X		X
Connecticut	X	X	X	X	X	X		
Delaware	X	X				X		
District of Columbia	X	X	X	X	X	X	X	X
Florida		X				X		
Georgia						X		
Hawaii	X	X	X	X	X	X	X	X
Idaho		X	X	X	X	X		
Illinois	X		X					
Indiana				X				
Iowa	X			X	X	X		
Kansas	X	X	X					
Kentucky			X				X	
Louisiana		X	X	X		X		
Maine	X		X	X	X	X		
Maryland	X	X	X	X	X	X	X	
Massachusetts	X	X	X	X	X	X		
Michigan	X	X	X	X				
Minnesota	X	X	X	X	X	X	X	
Mississippi						X		
Missouri	X		X					X
Montana		X	X	X	X	X		X
Nebraska	X	X	X					
Nevada		X	X	X		X		
New Hampshire					X	X		
New Jersey	X	X	X	X	X	X	X	
New Mexico		X				X		
New York	X	X	X	X	X	X	X	X
North Carolina			X		X			
North Dakota		X	X	X				
Ohio	X	X	X	X		X		X
Oklahoma		X	X	X	X	X		X
Oregon		X	X		X	X		
Pennsylvania	X		X	X	X	X	X	X
Rhode Island	X	X	X		X	X	X	X
South Carolina			X			X		
South Dakota						X		
Tennessee		X				X		
Texas			X	X		X		
Utah		X	X	X	X	X		X
Vermont	X	X	X	X	X	X		X
Virginia			X		X	X		
Washington	X	X	X		X	X	X	
West Virginia	X				X	X		
Wisconsin	X	X	X	X	X	X	X	X
Wyoming		X	X			X		

[1] Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

Table 4.2
Annual need and payment standards for Aid to Families with Dependent Children and annual income levels for the medically needy, by family size and jurisdiction: March 1984

Medicaid jurisdiction	AFDC[1] standard				Income level protected for maintenance for medically needy[2]		
	2-person family		4-person family				
	Need	Payment	Need	Payment	1-person family	2-person family	4-person family
Alabama	$3,456	$1,056	$5,760	$1,764	(2)	(2)	(2)
Alaska	7,404	7,404	9,300	9,300	(2)	(2)	(2)
Arkansas	2,316	1,620	3,276	2,292	$2,100	$2,196	$3,096
California	6,528	4,896	9,612	7,212	3,972	6,528	9,612
Colorado	3,864	3,180	5,952	4,896	(2)	(2)	(2)
Connecticut[3]	5,124	5,124	7,404	7,404	4,104	5,604	7,500
Delaware	2,544	2,544	4,032	4,032	(2)	(2)	(2)
District of Columbia	5,544	2,844	8,580	4,392	—	—	—
Florida	3,564	2,136	5,616	3,276	(2)	(2)	(2)
Georgia	3,672	2,028	5,184	2,856	(2)	(2)	(2)
Hawaii	4,680	4,680	6,552	6,552	3,600	4,800	6,600
Idaho	5,352	2,940	6,648	3,648	(2)	(2)	(2)
Illinois[3]	5,544	3,000	8,556	4,416	2,856	3,000	4,416
Indiana	2,964	2,664	4,356	3,924	(2)	(2)	(2)
Iowa	4,800	3,660	6,864	5,028	(2)	(2)	(2)
Kansas	3,672	3,672	4,932	4,932	3,780	4,920	5,160
Kentucky	1,944	1,944	2,820	2,820	2,196	2,604	3,804
Louisiana	5,256	1,656	9,000	2,808	1,200	2,304	3,804
Maine	4,188	3,036	7,116	5,160	3,240	3,900	5,196
Maryland	3,492	2,760	5,400	4,260	3,204	3,708	4,704
Massachusetts	4,164	3,780	5,880	5,340	3,996	5,100	5,340
Michigan[3]	4,644	4,248	6,456	5,904	3,996	5,700	5,904
Minnesota	4,944	4,944	6,996	6,996	3,936	4,944	6,996
Mississippi	2,928	2,928	3,924	3,924	(2)	(2)	(2)
Missouri	3,000	2,508	4,380	3,660	(2)	(2)	(2)
Montana	4,044	3,348	6,156	5,100	3,768	4,500	5,100
Nebraska	3,360	3,360	5,040	5,040	4,500	4,500	6,300
Nevada	2,748	2,196	4,092	3,264	(2)	(2)	(2)
New Hampshire	3,672	3,672	4,920	4,920	3,024	3,672	4,344
New Jersey	3,276	3,276	4,968	4,968	(2)	(2)	(2)
New Mexico	1,464	1,464	2,496	2,496	(2)	(2)	(2)
New York	5,064	5,064	7,224	7,224	4,500	6,600	6,804
North Carolina	4,224	2,112	5,304	2,652	2,196	2,904	3,600
North Dakota	3,468	3,468	5,244	5,244	3,180	4,620	6,360
Ohio	5,160	2,724	7,716	4,116	(2)	(2)	(2)
Oklahoma	2,616	2,616	4,188	4,188	2,900	3,500	5,600
Oregon	3,744	3,744	5,352	5,352	—	—	—
Pennsylvania	5,628	3,276	8,100	4,980	4,200	4,404	5,496
Rhode Island	4,500	4,500	6,336	6,336	5,500	6,000	8,400
South Carolina	1,728	1,308	2,748	2,088	(2)	(2)	(2)
South Dakota	3,360	3,360	4,332	4,332	(2)	(2)	(2)
Tennessee	3,516	1,152	5,316	1,728	1,404	1,620	2,460
Texas	5,100	1,536	7,116	2,136	(2)	(2)	(2)
Utah	6,372	3,432	9,264	4,992	3,420	4,572	6,648
Vermont[3]	7,728	5,023	10,500	6,825	4,368	6,756	6,828
Virginia[3]	3,444	3,096	4,800	4,320	3,900	4,400	5,400
Washington	7,212	4,488	10,500	6,528	4,236	6,108	6,528
West Virginia	2,628	3,948	3,984	5,976	2,400	2,700	3,300
Wisconsin	7,248	6,156	8,640	7,344	4,968	6,996	8,640
Wyoming	3,480	3,480	4,260	4,260	(2)	(2)	(2)

[1] Aid to Families with Dependent Children.
[2] Medically needy not included in Medicaid program.
[3] No uniform standards throughout State. The highest standards in the range are shown.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

categorically needy spend-down, applies only to categories for which more restrictive eligibility criteria are imposed, should the State elect not to impose more restrictive criteria in all categories. Although the provisions are directed primarily at States choosing to impose more restrictive income standards, they are applicable to any State criteria that are more restrictive than those used under SSI. As a result of these provisions, even 209(b) States without a medically needy program must permit all individuals to spend down; however, non-209(b) States need not extend this coverage.

The option to cover certain additional groups as categorically needy was also offered to the States. These groups could be covered no matter which of the following three basic coverage options the State chose: persons eligible for but not receiving cash assistance (42 CFR 435.210), certain institutionalized persons (42 CFR 435.211 and 231), and individuals receiving only optional State supplements (42 CFR 435.230). States electing to make optional supplementary payments are permitted to limit these payments to reasonable classifications of categorically related individuals. The SSI-related groups eligible for Medicaid coverage in March 1984 are shown by jurisdiction in Table 4.3.

States have the option of covering two other groups. Section 2176 of OBRA-81, effective October 1, 1981, permits the Secretary of the Department of Health and Human Services (DHHS) to offer under a waiver an array of home and community-based services that an individual needs to avoid institutionalization. Regulations at 42 CFR 441, subpart G, specify that home and community-based services must be provided under a written plan of care to individuals who would otherwise require the level of care provided in a skilled nursing facility or intermediate care facility. Services may include case management, homemaker or home health aide services, personal care services, adult day health, habilitative services, respite care, and other services as approved by the Secretary, such as transportation, Meals on Wheels, hospice care, and counseling. Waivers are granted for a 3-year period and may be renewed. By June 10, 1987, 49 States had submitted 280 waiver requests for home and community-based services. Of these, 175 requests from 45 States had been approved.

Section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA), effective October 1, 1982, permits States to cover certain disabled children 18 years of age or under who live at home. These "model waivers" as they are called, are limited to 50 or fewer eligible individuals. States requesting a model waiver must determine that the individuals would have required institutional care, that care at home is appropriate, and that the estimated cost of noninstitutional care is no more expensive than the cost of institutional care. As of March 1986, requests for 39 model waivers had been received from 23 States; 22 of these from 15 States had been approved.

Medically needy

The medically needy program is one of the most important overall options for coverage that can be exercised under the Medicaid program. The general intent of the medically needy option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income and who have incurred relatively large medical bills (Figure 4.2). Since 1969, a State's medically needy income standard has been limited to 133 1/3 percent of the maximum AFDC assistance payment for a family of the same size. For Federal matching purposes, this means that the Federal Government recognizes as medically needy only those persons whose "countable" income does not exceed 133 1/3 percent of the maximum payment standard set by the State. Annual income levels for the medically needy in States with such as program are shown in Table 4.2.

Each State is required to employ a single statewide income standard when determining eligibility for medically needy individuals and families. (This requirement was removed by OBRA-81, allowing States to vary their medically needy income standard from one covered group to the next; however, it was reinstated by section 137 of TEFRA.)

Under the medically needy spend-down provision (42 CFR 435.831), persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses for purposes of determining their countable income. Included in these deductible medical services are: Medicare and other health insurance premiums, deductibles, or coinsurance charges; expenses incurred for medical and remedial services included in the State Medicaid plan; and expenses incurred for services not included in the State plan but recognized under State law.

State-only coverage

A State may extend Medicaid coverage to individuals not in the preceding groups only at its own expense. The Federal Government will not provide matching assistance in such cases. These groups are referred to as noncategorically medically needy, or "State-only," eligibles. They include:

- Individuals who are receiving or are eligible for general assistance under a statewide program.
- Persons 21-65 years of age who have "sufficient" income and resources to meet daily needs, but not medical expenses, and who are ineligible for Medicaid under the adult or AFDC categories.
- Persons with incomes above the federally established maximum for medically needy groups. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. For example, a young, single male over age 21 and living alone could, at State option, receive Medicaid benefits as a State-only eligible.

Table 4.3

Medicaid coverage under Supplemental Security Income, by jurisdiction: March 1984

Medicaid jurisdiction[2]	Included in SSI[1] State plan		Optional categorically needy				
	All SSI recipients	More restricted standard	State supplement recipients			Persons eligible for but not receiving aid	Persons eligible except for institutional status
			Aged	Blind	Disabled		
Alabama	X		X	X	X		X
Alaska	X		X	X	X	X	X
Arkansas	X						X
California	X		X	X	X		
Colorado	X		X				X
Connecticut		X	X	X	X	X	X
Delaware	X						X
District of Columbia	X					X	X
Florida	X						X
Georgia	X						X
Hawaii		X	X	X	X	X	X
Idaho	X		X	X	X	X	X
Illinois		X	X	X	X		
Indiana		X					
Iowa	X			X		X	X
Kansas	X						
Kentucky	X						
Louisiana	X						X
Maine	X					X	X
Maryland	X					X	X
Massachusetts	X		X	X	X	X	X
Michigan	X		X	X	X		
Minnesota		X	X	X	X	X	X
Mississippi	X						X
Missouri		X		X			
Montana	X					X	X
Nebraska		X	X	X	X		
Nevada	X		X	X			X
New Hampshire		X	X	X	X	X	X
New Jersey	X		X	X	X	X	X
New Mexico	X						X
New York	X		X	X	X	X	X
North Carolina		X	X	X	X	X	
North Dakota		X					
Ohio		X					X
Oklahoma		X	X	X	X	X	X
Oregon	X		X	X	X	X	X
Pennsylvania	X		X	X	X	X	X
Rhode Island	X		X	X	X	X	X
South Carolina	X						X
South Dakota	X						X
Tennessee	X						X
Texas	X						X
Utah		X				X	X
Vermont	X		X	X	X	X	X
Virginia		X				X	X
Washington	X		X	X	X	X	X
West Virginia	X					X	X
Wisconsin	X		X	X	X	X	X
Wyoming	X						X

[1] Supplemental Security Income.
[2] Eligibility determination for the territories is based on separate regulations, which are found in 42 *Code of Federal Regulations*, part 436.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

Figure 4.2

Eligibility coverage of the medically needy: March 31, 1984

Eligibility criteria for the medically needy:

- Member of categorically related group
- Income standard met or income more than allowed but medical expenses incurred are at least equal to the difference between income and the applicable income standard
- Resource standard

Populations for which coverage is:

Mandatory	Optional
• All pregnant women during the course of their pregnancy (42 CFR 435.301 b 1 (i))	• Caretaker relatives (42 CFR 435.310)
• All individuals, or reasonable classifications of those individuals, under age 21 (42 CFR 435.308)	• Aged (42 CFR 435.320)
	• Blind (42 CFR 435.322)
	• Disabled (42 CFR 435.324)
• Blind and disabled individuals eligible in December 1973 (42 CFR 435.340)	• Aged, blind, and disabled in States imposing more restrictive eligibility requirements than Supplemental Security Income (42 CFR 435.330)

NOTE: CFR = *Code of Federal Regulations.*

SOURCE: *Code of Federal Regulations:* Public Health. Title 42, Chapter IV. Office of the Federal Register, National Archives and Records Administration. Washington. U.S. Government Printing Office.

Recipients

In this section, data on Medicaid recipients are presented by maintenance assistance status, eligibility category, and demographic characteristics. The percent distribution of Medicaid recipients by basis of eligibility and maintenance assistance status in fiscal year 1983 is shown in Table 4.4.

Individuals eligible for Medicaid are classified into two major groups according to their maintenance assistance status. "Cash assistance" recipients are those who receive cash assistance for their basic necessities under public assistance programs. "Medical assistance only" individuals are those who do not receive cash assistance. This group includes both the "medically needy" and "categorically eligible" persons not receiving cash assistance. Of the approximately 21.5 million Medicaid recipients in fiscal year 1983, the majority (73.1 percent) received cash assistance. About 3.2 million Medicaid recipients were 65 years of age or over, and 54.8 percent of them received cash assistance.

Within the two maintenance assistance groups, persons receiving Medicaid services are classified by basis of eligibility. Eligibility groups include persons aged 65 or over, the blind, the disabled, dependent children under age 21, and adults in families with dependent children. Some States extend Medicaid coverage to children not in any of these categories. Such children are classified as "other Title XIX recipients" and do not receive cash assistance. State-only eligibles are not included in Table 4.4.

In Table 4.5, the number of Medicaid recipients in fiscal year 1983 is shown for each jurisdiction. Programs are ranked by percent of total recipients. The cumulative percent of national recipients and the distribution of recipients by eligibility category are also shown. Sixty-nine percent of all recipients were in the AFDC category; 15 percent were in the group aged 65 or over. Cumulatively, six programs—California, New York, Puerto Rico, Michigan, Pennsylvania, and Illinois—accounted for nearly 50 percent of all Medicaid recipients, and 17 programs served 76 percent of all Medicaid recipients.

The distributions of recipients for each Medicaid program by age, sex, and race or ethnic origin are shown in Table 4.6. During fiscal year 1983, 50.2 percent of total recipients were under 21 years of age and 18.3 percent were 65 years of age or over. Females accounted for 64.1 percent of total recipients.

Service coverage and limitations

Title XIX regulations require each Medicaid program to offer a basic set of services to all categorically needy persons. States receive Federal financial participation (FFP) for these basic services as well as certain optional services they may elect to cover. States may limit the scope of coverage for both required and optional services, but they must make service coverage uniform throughout their State. (This "statewideness" rule may be waived for a limited period of time for the purpose of conducting special demonstration studies. OBRA-81 also authorizes waivers of statewideness under federally approved section 2176 home and community-based service programs.)

All States participating in Medicaid must cover the following basic services for all categorically needy recipients:

- Inpatient hospital services, other than services in an institution for tuberculosis or mental disease, that are ordinarily furnished in a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or dentist. The hospital must be licensed or formally approved as a hospital by a designated State standard-setting authority, and it must either be qualified to participate under Medicare or have been determined to currently meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program (42 CFR 440.10).

- Outpatient hospital services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services, that are furnished by or under the direction of a physician or dentist to a hospital outpatient. The hospital must meet the same requirements as for inpatient services: It must be licensed or formally approved as a hospital and must either be qualified to participate under Medicare or meet the requirements for such participation (42 CFR 440.20 (a)).
- Rural health clinic services in certified clinics that are furnished by a physician or by a physician's assistant, nurse practitioner, nurse-midwife, or other specialized nurse practitioner in States where those professionals are not prohibited by State law from furnishing primary health care (42 CFR 440.20 (b)).
- Other laboratory and X-ray services, including professional and technical laboratory and radiological services, that are ordered by a physician or other licensed practitioner within the scope of his or her practice as defined by State law. These services must be provided to a patient by or under the direction of a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. To be eligible for Medicaid coverage, services must be provided to a patient by a laboratory that is qualified to participate under Medicare or is determined to meet the requirements for such participation (42 CFR 440.30).
- Skilled nursing facility (SNF) services for individuals 21 years of age or over, other than services in an institution for tuberculosis or mental disease. These services must be ordered by and furnished under the direction of a physician. The facility must be qualified for participation in Medicaid (42 CFR 440.40 (a)).
- Physicians' services, whether provided in the office, the patient's home, a hospital, an SNF, or elsewhere. Physicians' services are defined to include services provided within the scope of practice of the profession as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (42 CFR 440.50).
- Early and periodic screening, diagnosis, and treatment (EPSDT) for recipients under age 21. EPSDT includes screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR 440.40 (b)).
- Family planning services and supplies for individuals of childbearing age who are eligible for Medicaid and desire such services and supplies (42 CFR 440.40 (c)).
- Home health services provided in the patient's residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency or registered nurse (when there is no home health agency in the area), home health aide services provided by a home health agency, and medical supplies, equipment, and appliances suitable for use in the home (42 CFR 440.70 and 42 CFR 441.15).
- Services concerned with the management of the care of mothers and newborns that are furnished by a licensed nurse-midwife within the scope of practice authorized by State law (42 CFR 440.165).

As of October 1, 1981, States with a medically needy program must cover the following services (42 CFR 440.220): prenatal care and delivery services for pregnant women and ambulatory services as defined in the State plan for individuals under age 18 and individuals entitled to institutional services. Home health services for any individual entitled to SNF services must also be covered (42 CFR 440.70).

In addition to federally required services, each State may offer coverage of certain optional services:

- Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include, among others, chiropractors (limited coverage), optometrists, and podiatrists (42 CFR 440.60).
- Home health services in addition to those required under 42 CFR 440.70. Specifically included are physical therapy, occupational therapy, speech pathology, and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services (42 CFR 440.70 (b)(4)).
- Private-duty nursing services, defined as nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician. These services may be provided to a patient in his or her own home or in a hospital or SNF when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF (42 CFR 440.80).
- Clinic services, that is, preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility that is not part of a hospital but that is organized and operated to provide medical care to outpatients (42 CFR 440.90).
- Dental services in addition to those required to be provided to persons under 21 years of age in the State's EPSDT program (42 CFR 440.100).
- Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary. These services must be rendered by or under the supervision of an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession and under the prescription or referral of a physician (42 CFR 440.110).
- Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses. Prescribed drugs that may be provided are simple or compounded substances or mixtures of substances prescribed by a physician or other licensed practitioner (42 CFR 440.120).

- Other diagnostic, screening, preventive, and rehabilitative services (42 CFR 440.130).
- Inpatient hospital services, SNF services, and intermediate care facility (ICF) services to persons 65 years of age or over in institutions for tuberculosis or mental disease (42 CFR 440.140).
- ICF services, other than services in an institution for tuberculosis or mental diseases, for the physically ill or mentally retarded (42 CFR 440.150).
- Inpatient psychiatric hospital services for persons under age 21 (42 CFR 440.160).
- Services concerned with the management of the care of mothers and newborns furnished by a licensed nurse-midwife within the scope of practice authorized by State law (42 CFR 440.165).
- Other medical or remedial care recognized under State law. Such additional items and services include transportation, emergency hospital services, nonprofessional personal care services prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoriums and nursing services, and SNF services for persons under 21 years of age (42 CFR 440.170).
- Home and community-based services (under waiver agreement) that an individual would need to avoid institutionalization (42 CFR 441, subpart G).

The optional services each State offered the categorically needy and medically needy as of October 1986 are presented in Table 4.7. The most frequently offered optional services, by the number of States and territories offering them, were prescribed drugs (51), optometrists' services (50), clinic services (50), and ICF services (50). The least offered were case management and hospice services (1 each).

Once a State has selected a benefit package, Federal regulations require that the State plan specify the amount and/or duration of each covered service. Benefits must be sufficient in amount, duration, and scope to reasonably achieve their purpose (42 CFR 440.230). They also must be comparable for all categorically needy recipients and within each medically needy group (42 CFR 440.240). States may not impose limits on the basis of "diagnosis, type of illness, or condition." Within these general guidelines, States are free to set whatever service limits they choose.

Limitations imposed by States on four mandatory services (inpatient hospital, outpatient hospital, home health, and physicians' services) and one optional service (long-term care) are shown in Table 4.8. Forty-five States (including the District of Columbia) limit inpatient hospital services, 40 States limit outpatient hospital services, and 45 limit physicians' services. Of services authorized under home health care, 34 States limit part-time nursing services; 34 limit aide services; 42 either limit or do not cover physical, occupational, or speech and hearing therapy; and 45 limit medical supplies and equipment. Thirty-four States limit services covered in ICF's, and 28 either do not offer or limit services covered in ICF's/MR.

The limitations imposed by States on prescription drugs as of March 1984 are shown in Table 4.9. Two

Table 4.4
Number and percent distribution of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal year 1983

Basis of eligibility	Number of recipients in thousands	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	21,492.5	73.1	26.9
Age 65 or over	3,246.1	54.8	45.2
Blind	76.3	86.8	13.2
Disabled	2,955.2	74.6	25.4
Dependent children under age 21	9,418.3	84.7	15.3
Adults in families with dependent children	5,466.8	80.5	19.5
Other Title XIX	1,325.3	NA	100.0

NOTE: The sum of recipients exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

States, Alaska and Wyoming, did not provide prescribed drugs as a separate service to Medicaid recipients. Eighteen States imposed a fixed or variable copayment on each prescription; 11 limited the number of prescriptions per recipient. Twenty-eight States set limits on the number of days that must elapse before a single prescription can be refilled. All but 10 excluded most over-the-counter drugs from coverage, and all but 7 employed formulary restrictions of varying stringency.

Prior to October 1, 1982, States were permitted to charge Medicaid recipients copayments, except for mandatory services provided to the categorically needy. Section 131 of TEFRA now enables States to charge copayments to both categorically and medically needy recipients, except for the following: services provided to individuals under age 18 (or up to age 21 at State option), services related to pregnancy (or any services provided to pregnant women), services furnished to institutionalized individuals who are required to expend all of their income above their personal needs allowance, emergency services, and family planning services and supplies.

Utilization

In this section, data are presented on the use of medical services by Medicaid recipients. The distribution of Medicaid recipients by type of medical service, number of recipients, and volume of services received are shown in the tables for general hospitals, SNF's, ICF's, physicians' services, and drug prescriptions. Recipient counts for each type of service are unduplicated, although recipients may have received more than one type of service. For example, the same recipient may have used inpatient hospital services, physicians' services, and outpatient hospital services. Thus, the total

Table 4.5

Number and percent distribution of Medicaid recipients, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1983

Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other Title XIX
				Percent distribution				
All jurisdictions	21,492.5	100.0	100.0	15.1	0.4	13.8	69.3	6.2
California	3,499.9	16.3	16.3	16.0	0.7	14.7	67.0	5.7
New York	2,160.6	10.1	26.4	16.1	0.2	14.7	68.4	7.5
Puerto Rico	1,547.1	7.2	33.6	0.0	0.0	11.3	45.8	42.8
Michigan	1,187.6	5.5	39.1	7.3	0.2	10.0	88.2	2.0
Pennsylvania	1,167.2	5.4	44.5	11.2	0.2	11.5	78.2	6.5
Illinois	1,051.0	4.9	49.4	7.8	0.1	13.8	83.2	0.7
Ohio	910.6	4.2	53.6	10.0	0.2	10.2	82.6	0.0
Texas	680.1	3.2	56.8	33.0	0.6	15.3	54.7	0.3
New Jersey	611.9	2.8	59.6	9.6	0.2	10.4	80.9	2.3
Massachusetts	579.1	2.7	62.3	24.0	0.0	14.1	58.0	4.0
Florida	555.2	2.6	64.9	19.8	0.5	17.2	65.2	0.0
Wisconsin	480.1	2.2	67.1	13.9	0.2	10.6	74.3	1.0
Georgia	441.1	2.1	69.2	20.3	0.6	20.3	62.7	0.6
Kentucky	388.0	1.8	71.0	15.3	0.5	16.0	73.0	0.9
Louisiana	378.0	1.8	72.8	25.6	0.4	17.5	59.5	1.6
North Carolina	349.1	1.6	74.4	23.8	0.7	15.2	70.2	1.9
Missouri	341.6	1.6	76.0	19.2	0.5	13.6	65.4	1.3
Tennessee	341.2	1.6	77.6	21.7	1.0	21.9	55.4	0.0
Maryland	328.0	1.5	79.1	11.4	0.1	10.3	78.2	0.0
Minnesota	326.4	1.5	80.6	15.9	0.2	9.5	66.4	8.1
Alabama	311.3	1.4	82.0	27.8	0.6	19.9	56.0	1.2
Virginia	306.4	1.4	83.4	20.2	0.4	15.5	68.2	1.8
Mississippi	290.5	1.4	84.8	22.5	0.6	18.7	57.9	0.3
Indiana	271.7	1.3	86.1	13.8	0.4	13.3	76.9	0.0
Washington	257.6	1.2	87.3	15.1	0.1	13.9	77.6	0.0
South Carolina	236.2	1.1	88.4	19.9	0.8	20.9	90.5	0.1
Oklahoma	232.5	1.1	89.5	24.6	0.2	10.6	64.5	0.1
Connecticut	215.5	1.0	90.5	14.8	0.1	9.3	69.0	6.8
Arkansas	190.3	0.9	91.4	28.5	0.8	21.6	44.3	6.8
Iowa	189.5	0.9	92.3	15.6	0.4	9.7	76.0	6.3
West Virginia	177.4	0.8	93.1	14.1	0.2	15.0	73.8	1.0
Oregon	152.1	0.7	93.8	13.3	0.7	12.0	76.6	4.6
Colorado	147.6	0.7	94.5	25.3	0.2	12.1	74.7	3.9
Kansas	147.2	0.7	95.2	16.6	0.2	10.6	77.3	1.5
Maine	122.2	0.6	95.8	17.0	0.2	13.7	78.9	1.9
District of Columbia	117.7	0.5	96.3	10.2	0.1	12.4	77.3	0.0
Rhode Island	104.6	0.5	96.8	19.8	0.3	16.1	62.7	1.2
Hawaii	100.3	0.5	97.3	12.6	0.2	7.6	89.1	1.0
New Mexico	84.4	0.4	97.7	14.2	0.6	18.5	65.3	1.4
Nebraska	84.0	0.4	98.1	17.4	0.2	10.6	68.1	3.6
Utah	66.0	0.3	98.4	21.9	0.2	15.0	71.5	13.4
Vermont	53.6	0.2	98.8	14.3	0.2	11.8	72.0	1.8
Delaware	45.6	0.2	99.0	10.6	0.2	10.4	75.4	6.9
Montana	44.8	0.2	99.2	16.8	0.3	15.9	65.4	1.6
New Hampshire	41.7	0.2	99.4	22.1	0.9	13.3	83.4	0.4
Idaho	39.2	0.2	99.6	16.7	0.2	15.0	74.2	8.3
South Dakota	33.5	0.2	99.7	25.3	0.4	16.2	61.6	3.0
North Dakota	31.9	0.1	99.8	34.6	0.2	13.8	60.4	10.0
Nevada	27.9	0.1	99.9	22.2	1.5	16.3	60.0	4.7
Alaska	20.0	0.1	100.0	11.1	0.3	11.7	64.0	14.3
Wyoming	14.2	0.1	100.0	18.1	0.4	7.6	88.5	0.3
Virgin Islands	11.1	0.1	100.0	10.6	0.1	2.6	78.2	8.6

[1] The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.
[2] Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.6

Percent distribution of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin				
		Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
							Percent distribution				
All jurisdictions	21,492.5	50.2	31.5	18.3	35.9	64.1	55.8	36.2	1.5	1.0	5.5
Alabama	311.3	38.3	29.7	32.0	32.7	67.3	38.2	61.6	0.1	0.2	0.0
Alaska	20.0	57.8	31.1	11.1	36.7	63.3	46.0	9.1	36.5	4.0	4.4
Arkansas	190.3	36.5	26.6	36.8	35.0	65.0	54.5	45.3	0.0	0.1	0.1
California	3,499.9	34.5	40.1	25.4	37.5	62.5	—	—	—	—	—
Colorado	147.6	48.6	30.1	21.3	35.4	64.6	54.2	10.8	0.6	0.2	34.1
Connecticut	215.5	46.4	27.9	25.7	35.4	64.6	64.8	35.2	0.0	0.0	0.0
Delaware	45.6	60.0	28.9	11.1	34.9	65.1	41.4	53.8	0.0	0.4	4.3
District of Columbia	117.7	51.3	36.0	12.8	33.4	66.6	2.9	97.0	0.0	0.1	0.0
Florida	555.2	48.0	27.8	24.2	30.4	69.6	46.2	49.7	0.0	0.2	3.9
Georgia	441.1	45.3	29.4	25.3	32.8	67.2	35.0	64.9	0.0	0.1	0.1
Hawaii	100.3	57.5	31.4	11.1	40.6	59.4	24.4	1.1	0.0	73.1	1.4
Idaho	39.2	54.0	30.5	15.6	35.1	64.9	89.6	0.7	0.7	2.8	6.3
Illinois	1,051.0	56.8	33.7	9.5	36.8	63.2	38.1	52.5	0.1	0.7	8.6
Indiana	271.7	50.0	33.8	16.2	33.2	66.8	67.0	1.7	30.8	0.1	0.4
Iowa	189.5	52.6	31.7	15.7	36.5	63.5	90.3	7.0	0.5	1.3	1.0
Kansas	147.2	53.4	30.6	15.9	36.3	63.7	73.3	22.3	0.9	0.0	3.5
Kentucky	388.0	50.2	32.4	17.4	37.7	62.3	94.3	5.7	0.0	0.0	0.0
Louisiana	378.0	44.4	30.5	25.0	34.4	65.6	29.5	70.5	0.0	0.0	0.0
Maine	122.2	48.6	32.5	19.0	41.3	58.7	—	—	—	—	—
Maryland	328.0	53.4	33.8	12.8	34.4	65.6	42.4	57.6	0.0	0.0	0.0
Massachusetts	579.1	42.9	33.1	24.0	32.0	68.0	—	—	—	—	—
Michigan	1,187.6	61.7	30.6	7.7	38.8	61.2	61.6	35.1	0.4	0.5	2.3
Minnesota	326.4	50.6	31.5	17.9	37.9	62.1	84.0	4.3	3.9	6.8	0.9
Mississippi	290.5	46.4	26.5	27.1	33.4	66.6	23.2	76.6	0.1	0.1	0.0
Missouri	341.6	38.4	27.5	34.1	33.6	66.4	64.2	35.5	0.1	0.0	0.2
Montana	44.8	47.9	31.5	20.6	35.5	64.5	82.0	0.3	11.7	4.9	1.1
Nebraska	84.0	51.7	30.7	17.7	35.7	64.3	74.6	17.1	3.5	1.1	3.7
Nevada	27.9	51.5	25.2	23.3	33.0	67.0	62.7	28.7	2.8	1.0	4.9
New Hampshire	41.7	45.5	33.0	21.5	34.5	65.5	—	—	—	—	—
New Jersey	611.9	58.6	30.2	11.2	35.0	65.0	37.5	41.9	0.1	0.4	20.1
New Mexico	84.4	47.1	33.9	19.0	35.4	64.6	87.0	4.7	8.3	0.0	0.0
New York	2,160.6	50.2	32.1	17.7	35.8	64.2	67.4	25.7	0.5	0.3	6.1
North Carolina	349.1	44.5	36.3	19.2	32.6	67.4	38.8	58.7	0.3	0.1	2.1
North Dakota	31.9	47.0	28.7	24.3	36.5	63.5	80.5	0.4	17.9	0.6	0.6
Ohio	910.6	55.0	35.0	10.0	36.8	63.2	68.2	30.5	0.0	0.0	1.3
Oklahoma	232.5	45.0	30.1	24.9	35.0	65.0	68.7	22.8	7.3	0.4	0.9
Oregon	152.1	50.1	35.3	14.6	34.7	65.3	86.5	6.9	3.2	1.5	1.9
Pennsylvania	1,167.2	55.9	32.4	11.6	37.7	62.3	62.2	31.8	0.0	0.5	5.5
Rhode Island	104.6	47.4	27.7	24.9	35.3	64.7	76.4	13.1	0.1	3.1	7.3
South Carolina	236.2	45.1	31.2	23.7	31.4	68.6	27.8	72.0	0.0	0.1	0.0

See footnote at end of table.

Table 4.6—Continued

Percent distribution of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin				
		Under 21 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent distribution					
South Dakota	33.5	45.7	27.8	26.5	35.0	65.0	69.7	0.1	30.1	0.0	0.0
Tennessee	341.2	42.8	30.6	26.6	33.8	66.2	57.2	42.7	0.0	0.0	0.1
Texas	680.1	41.4	26.6	32.1	33.7	66.3	39.3	31.8	0.1	0.7	28.1
Utah	66.0	59.2	29.4	11.4	36.5	63.5	84.9	1.4	3.1	1.1	9.5
Vermont	53.6	51.0	32.8	16.2	37.9	62.1	99.2	0.2	0.1	0.4	0.1
Virginia	306.4	50.1	31.4	18.5	34.3	65.7	43.3	55.6	0.1	0.7	0.3
Washington	257.6	51.4	33.7	14.9	35.1	64.9	82.8	8.2	3.7	1.2	4.0
West Virginia	177.4	51.3	35.2	13.6	36.3	63.7	93.9	6.1	0.0	0.0	0.0
Wisconsin	480.1	51.9	32.7	15.4	38.5	61.5	73.2	18.7	2.8	1.5	3.8
Wyoming	14.2	56.5	29.1	14.4	32.9	67.1	84.1	3.0	1.4	0.2	11.3
Puerto Rico	1,547.1	44.1	48.1	7.7	41.2	58.8	0.0	0.0	0.0	0.0	100.0
Virgin Islands	11.1	60.8	28.6	10.6	32.0	68.0	—	—	—	—	—

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.7

Medicaid services, by jurisdiction: October 1, 1986

Basic required Medicaid services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services.
- Outpatient hospital services.
- Rural health clinic services.
- Other laboratory and X-ray services.
- Skilled nursing facility services and home health services for individuals 21 and older.
- Early and periodic screening, diagnosis, and treatment for individuals under 21.
- Family planning services and supplies.
- Physician services.
- Nurse Midwife services.

Optional services in State Medicaid programs

FMAP[1]	● CN[2] + Both CN and MN[3] Basic required Medicaid services see above		Podiatrists' services	Optometrists' services	Chiropractors' services	Other practitioners' services	Private duty nursing	Clinic services	Dental services	Physical therapy	Occupational therapy	Speech, hearing, and language disorder	Prescribed drugs	Dentures	Prosthetic devices	Eyeglasses	Diagnostic services
72.41	●	Alabama		●				●					●		●	●	
50.00	●	Alaska		●	●			●	●	●	●	●			●	●	
		American Samoa[4]															
62.13		Arizona[5]															
74.02	+	Arkansas		+	+	+		+	+				+	+	+	+	
50.00	+	California	+	+	+	+		+	+	+	+	+	+	+	+	+	+
50.00	●	Colorado	●	●		●		●	●				●			●	
50.00	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+	+
50.00	●	Delaware	●	●		●	●	●					●		●		●
50.00	+	D.C.	+	+		+	+	+		+	+	+	+		+	+	+
55.54	+	Florida	+	+		+		+	+			+	+	+	+	+	
64.54	+	Georgia	+	+		+		+	+				+	+	+	+	
50.00	●	Guam		●				●	●			●	●			●	
51.29	+	Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+
71.08	●	Idaho	●	●	●	●		●		●	●		●				
50.00	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
62.92	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
60.39	+	Iowa	+	+	+	+		+	+	+	+	+	+	+	+	+	+
51.39	+	Kansas	+	+	+	+		+	+	+	+	+	+	+	+	+	
70.75	+	Kentucky	+	+		+		+	+	+	+	+	+		+	+	+
65.77	+	Louisiana		+				+	+				+	+	+	+	
68.07	+	Maine	+	+	+	●	+		+	+	+	+	+		+	+	+
50.00	+	Maryland	+	+				+	+	+		+	+	+	+	+	
50.00	+	Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
56.88	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+
52.98	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
78.50	●	Mississippi		●					●				●			●	
59.85	●	Missouri	●	●				●	●				●	●	●	●	
67.44	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+
58.06	+	Nebraska	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
50.00	●	Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
53.28	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+
50.00	+	New Jersey[7]	+	+	+	+		+	+	+	+	+	+	+	+	+	+
69.68	●	New Mexico	●	●		●		●	●	●			●	●	●	●	
50.00	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+
68.40	+	North Carolina	+	+	+			+	+				+	+		+	+
56.41	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+
50.00	+	N. Mariana Islands		+				+	+	+			+	+	+	+	
58.27	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●	
69.86	+	Oklahoma	+	+		+		+	+				+		+	+	
62.47	+	Oregon	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
57.28	+	Pennsylvania	+	+	+			+	●				●	●	●		
50.00	+	Puerto Rico[6]						+									
55.38	+	Rhode Island	●	+					+				+	+	+	●	
72.23	+	South Carolina	+	+				+	+				+		+	+	
67.45	●	South Dakota			●			●	●	●			●	●	●		
70.26	+	Tennessee						+		+	+	+	+	+	+	+	
55.16	+	Texas	+	+	+	+							+		+	+	
73.21	+	Utah	+	+		+		+	+	+		+	+	+	+	+	+
67.37	+	Vermont	+	+	+	+		+		+	+	+	+		+	+	
50.00	+	Virgin Islands[6]						+					+	+	+	+	
51.86	+	Virginia	+	+				+		+	+	+	+				
52.52	+	Washington	+	+	●	+	+	+		+		●	+	+	+	+	●
72.59	+	West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+	
57.58	+	Wisconsin		●	●	●	●	+	●	+	+	+	+	●	+	●	●
54.20	●	Wyoming		●				●		●					●		
●	14	●	10	15	8	10	5	14	13	8	5	7	14	9	12	13	4
+	40	+	31	35	20	25	14	36	29	28	22	26	37	27	35	34	19
	54	Total	41	50	28	35	19	50	42	36	27	33	51	36	47	47	23

[1] Federal Medicaid assistance percentage (FMAP): Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1986 through September 30, 1987 (Fiscal year 1987).

[2] Categorically Needy: Individuals receiving federally supported financial assistance.

[3] Medically Needy: Individuals who are eligible for medical but not for financial assistance.

[4] American Samoa operates under a special Medicaid waivered program

[5] Arizona operates a medical assistance program under a Section 1115 demonstration project.

[6] All services are provided through public health facilities.

[7] All services indicated as available to the Medically Needy are not available to all Medically Needy Groups.

Table 4.7 — Continued

Medicaid services, by jurisdiction: October 1, 1986

Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible or medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Basic required Medicaid services

Optional services in State Medicaid programs

Screening services	Preventive services	Rehabilitative services	Services for age 65 or older in mental institution: A. Inpatient hospital services	Services for age 65 or older in mental institution: B. SNF services	Services for age 65 or older in mental institution: C. ICF services	Intermediate care facility services	ICF for mentally retarded	Inpatient psychiatric services for under age 22	Christian Science nurses	Christian Science sanitoria	SNF for under age 21	Emergency hospital services	Personal care services	Transportation services	Case management services	Hospice services	Total additional services	
	•			•	•	•	•				•	•	•	•			14	AL
			•			•	•	•			•	•	•				16	AK
																		AS
																		AZ
		+	+	•	•	•	•	+			•	+	•	+			20	AR
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			29	CA
			•	•	•	•	•	•			•	•		•			16	CO
+	+	+	+			+	+	+		+	+			+			24	CT
			•		•	•	•				•	•					14	DE
+	+	+	+	+	+	+	+	+			+	+	+	+			25	DC
		+	+			+	+			+		+		+			17	FL
						+	+				+			+			13	GA
												•					7	GU
+	+	+				+	+				+	+	+	+			22	HI
		•			•	•	•				•	•					14	ID
	+	+	+	+	+	+	+	+		+	+	+		+			27	IL
•	•	•	•			•	•	•	•	•	•	•	•	•			28	IN
	+	+	•			•	•	•			+	+					22	IA
		+	+		+	+	+	+			+	+	+				22	KS
	+	+	+	+	+	+	+	+			+	+		+			23	KY
		+	•	•	•	•	•	•			•			+			16	LA
+	+	+				+	+	+	+	+	+	•	+	+			25	ME
			+			+	+	+			+	+	+				17	MD
+	+	+	+	+	+	+	+	+	+	+	+	+	+	+			30	MA
		+	+	+	+	+	+	+		+	+	+	+	+			26	MI
+	+	+	+	+	+	+	+	+		+	+	+	+	+			29	MN
						•	•			•	•	•		•			10	MS
			•			•	•	•					•				13	MO
+	+	+	+	+	+	+	+	+			+	+	+	+			27	MT
			+	+	+	+	+	+			+	+	+				23	NB
		•	•	•	•	•	•				•	•	•	•			24	NV
+	+	+	+		+	+	+		+	+	+	+	+				26	NH
+	+	+	•	•	•	•	•	•		•	•	+	+	+			28	NJ
		•				•	•				•	•		•			16	NM
+	+	+	+			+	+	+			+	+	+	+		+	26	NY
+	+	+	+		+	+	+	+			+		+	+			20	NC
+	+	+	+			+	+	+			+	+		+			24	ND
												+	+	+			11	NMI
		•	•	•	•	•	•	•		•	•	•		•			25	OH
		+	+			+	+	+			+		+	+			16	OK
	+	+	•			+	+	+		+	+	+	+				25	OR
			+	+	+	+	+	+			+	+					16	PA
																	1	PR
			+			+	+				+			+			12	RI
		+	+	+	+	+	+	+			+	+		+			17	SC
			•	•	•	•	•				•	•	•	•			16	SD
			+	+	+	+	+	+	+	+	+	+	+	+			20	TN
		+				+	+			+	+	+	+	+			15	TX
+	+	+	+	+	+	+	+	+			+	+	+	+	+		26	UT
			+			+	+	+			+	+		+			18	VT
														+			6	VI
			•	•	•	+	•			+	+	+					15	VA
	+	+	+	+	+	+	+	+			+	+					23	WA
						+	+	+			+	+					18	WV
•	•	•	•			+	+	•		+	+	•	+	+			26	WI
		•	•			•					•			•			9	WY
2	3	8	16	9	11	18	18	9	1	5	15	15	7	10	0	0		
14	19	26	25	14	17	32	31	26	5	13	33	29	22	28	1	1		
16	22	34	41	23	28	50	49	35	6	18	48	44	29	38	1	1		

NOTE: The data shown were reported by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

SOURCE: Department of Health and Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs.

Table 4.8

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup. speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Alabama	MAX 12		PAR			LD	LD				MVR 3		PAR				PAR VLD	PAR VLD	RSL	NP	PAR	PAR
Alaska		PAR	PAR	PAR						OLD							PAR	PAR	PAR	PAR	PAR	PAR
Arkansas										OLD	MVR 12									LDS	PAR	PAR
California			PAR NC		NC							NC				OLD	PAR VLD	PAR VLD	PAR	PAR	PAR PRR	PAR PRR
Colorado					NC					OLD		NC					PAR	PAR	PAR	PAR	PAR PRR	PAR PRR
Connecticut			NC									NC					VLD	VLD				
Delaware		PAR					LD		LD						LD	OLD						
District of Columbia			PAR				LD			OLD		NC	PAR						PAR RSL	OLD		
Florida	MAX 45	PAR	NC	PAR								NC	NC			OLD			LDQ RSL	NP		
Georgia			PAR					NC			MVR 12	NC				OLD	VLD	VLD	PAR RSL	PAR VLD	PAR	PAR
Hawaii										OLD			PAR	LD					PAR		PAR	PAR
Idaho	MAX 40										MVR 6						VLD	VLD	PAR LDQ	LDS		
Illinois					NC	LD											PAR	PAR	PAR	PAR	OLD	
Indiana			PAR										PAR				PAR	HNC	PAR	PAR LDS	OLD	OLD

See footnotes at end or table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup. speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Iowa			PAR NC				LD	NC								OLD			OLD	LDS	OLD	
Kansas			NC			LD				OLD		NC	PAR	LD		OLD	OLD	HNC	PAR OLD	LDS OLD	OLD	OLD
Kentucky	MSP 14	PAR	PAR NC	PAR	NC					OLD		NC				OLD	OLD	HNC OLD	PAR	OLD	PAR PRR	PAR PRR
Louisiana	MAX 15				PAR		PAR			OLD			PAR			OLD	VLD OLD	VLD OLD	PAR OLD	LDS OLD		
Maine	MAX 30									OLD												
Maryland	MSP 20		PAR NC			LD		NC		OLD		NC	PAR	LD		OLD	OLD	OLD	OLD	LDS	PAR OLD	
Massachusetts																	OLD	OLD	OLD	OLD	PAR OLD	
Michigan			PAR NC		NC		LD	NC		OLD		NC	PAR	LD		OLD			OLD	LDS	PAR PRR	
Minnesota			PAR				LD	NC				NC	PAR						PAR OLD	OLD	PAR	
Mississippi	MAX 20					LD					MVR 12					OLD	VLD	VLD	LDQ	LDS VLD	PAR	PAR
Missouri	LD		LD		LD	LD			LD		LD		PAR LD	LD	LD		VLD OLD	VLD	LD	LDS OLD	LD	LD
Montana																	VLD	VLD	PAR	VLD LDS		

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup. speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Nebraska			PAR				LD			OLD		NC		LD				OLD	PAR LDQ		OLD	OLD
Nevada										OLD	MVR 24					OLD	PAR	PAR	PAR	PAR	PAR	PAR
New Hampshire											MVR 12						VLD	VLD	PAR	VLD LDS	PAR PRR	PAR PRR
New Jersey			PAR NC							OLD			PAR	OLD		OLD	PAR	PAR	PAR	PAR	PAR PRR	OLD
New Mexico			PAR					NC					PAR				PAR OLD	PAR OLD	PAR	PAR OLD		
New York					NC	LD				OLD							PAR	PAR	PAR	PAR	PAR	PAR
North Carolina			PAR					NC		OLD	MVR 24	NC		LD		OLD	OLD	OLD	OLD	LDS	PAR	PAR
North Dakota																						
Ohio			NC							OLD	MVR 48					OLD			OLD	PAR VLD	OLD	OLD
Oklahoma	MSP 10						PAR			OLD						OLD	VLD OLD	VLD OLD	OLD VLD	NC	PAR	PAR
Oregon	MAX 18		PAR										PAR				PAR	PAR	PAR	PAR	OLD	PAR
Pennsylvania			NC		NC	LD	LD		LD			NC	PAR			OLD	VLD OLD	VLD OLD	PAR	OLD		
Rhode Island			PAR				PAR			OLD		NC	PAR				PAR	PAR	PAR	PAR	PAR	PAR

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup. speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
South Carolina	MAX 12		PAR NC						LD		MVR 18						VLD OLD	HNC OLD	PAR RSL	LDS	PAR	PAR
South Dakota																	PAR	PAR	RSL	VLD PAR		OLD
Tennessee	MAX 14					LD					MVR 30						VLD	VLD	OLD	VLD OLD	OLD	
Texas	MSP 30							NC				NC				OLD	PAR VLD	PAR VLD	PAR OLD	NP	OLD	OLD
Utah			PAR						LD	OLD					LD				PAR	PAR VLD		
Vermont			PAR NC				LD	NC								OLD	OLD	OLD	OLD	OLD	OLD	
Virginia	MSP 21					LD				OLD						OLD			PAR RSL			
Washington										OLD							OLD	HNC OLD	PAR	PAR OLD		
West Virginia	MAX 20															OLD			PAR		PAR PRR	PAR PRR
Wisconsin			PAR							OLD			PAR			OLD			OLD	VLD PAR	OLD	OLD
Wyoming			NC									NC					OLD		OLD	OLD		NP

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Physicians' services																		
	Inpatient hospital	Long-term care facility	Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Alabama	VPD 1					MVR 12	PAR			PAR						LDS 1			OLD
Alaska								PAR										LD	
Arkansas	VPD 1				MVR 12	MVR 12		PAR									LD		
California							NC PAR	PAR			PAR LDS 24				LDS 24				OLD
Colorado																			
Connecticut		MVR 4					NC				PAR LDS 2								
Delaware	VPD 1									PAR						LD	LD	LD	LD
District of Columbia							NC	PAR											OLD
Florida	VPD 1	MVR 12						PAR				LDS 1							OLD
Georgia	VPD 1		MVR 12				PAR NC	PAR					LDS 2				LD		OLD
Hawaii		MVR 24																	
Idaho							NC			PAR	PAR LDS 57								

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Physicians' services																		
	Inpatient hospital	Long-term care facility	Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Illinois																			OLD
Indiana							PAR												
Iowa							NC										LD	LD	OLD
							PAR												
Kansas			MVR 12				PAR NC			PAR	PAR LDS 24								
Kentucky							NC				PAR LDS 4			LDS 1					OLD
Louisiana	VPD 1					MVR 12	PAR		PAR	PAR									OLD
Maine																			
Maryland							PAR NC	PAR									LD		OLD
Massachusetts								PAR							LD	LD			
Michigan		MVR 12					NC				PAR								OLD
Minnesota							PAR NC											LD	OLD
Mississippi	VPD 1	MVR 36				MVR 12													
Missouri	LD	LD	LD	LD	LD	LD	LD	LD		PAR LD	LD	LD		LDS 1			LD	LD	OLD
Montana							PAR NC									LDS 1			OLD

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Physicians' services																		
	Inpatient hospital	Long-term care facility	Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Nebraska											PAR						LD	LD	
Nevada			MVR 24														LD		
New Hampshire						MVR 18	PAR				LDS 12								OLD
New Jersey							PAR	PAR			PAR					OLD			OLD
New Mexico	VPD 2						PAR												OLD
New York																			
North Carolina						MVR 24	PAR NC				PAR LDS 2					LDS 1	LD		OLD
North Dakota																			
Ohio		MVR 12				MVR 48	NC		PAR									LD	OLD
Oklahoma	VPD 1	MVR 24	MVR 48	MVR 48															
Oregon								PAR		PAR									OLD
Pennsylvania	VPD 2												LDS 1			LDS 2			OLD
Rhode Island	LD	LD	LD		LD		PAR	PAR	PAR	PAR	PAR								OLD

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1984

Medicaid jurisdiction	Physicians' services																		
	Inpatient hospital	Long-term care facility	Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
South Carolina	VPD 1		MVR 18			MVR 12	NC					LDS 3							
South Dakota							NC												
Tennessee	VPD 1		MVR 24				PAR												
Texas											PAR								
Utah							PAR	PAR										LD	
Vermont		MVR 12					PAR NC	PAR			LDQ							LD	OLD
Virginia							PAR NC				PAR LDS 26								
Washington	VPD 1	MVR 24					NC	PAR			PAR LDS 12								OLD
West Virginia																			
Wisconsin							PAR NC												
Wyoming		MVR 12					NC							LDS 1			LD		

NOTE: Following is a list of abbreviations used in this table:

HNC—Homemaker services not provided.
LD—Limited.
LDQ—Limit on quantity or dollars.
LDS—Limit on frequency of service per year, may be followed by number of services.
MAX—Limit on number of days per year, followed by number of days.
MSP—Limit on number of days per spell of illness, followed by number of days.
MVR—Limit on number of visits per year, followed by number of visits.
NC—Not covered.
NP—Not provided.
OLD—Other limits.
PAR—Prior authorization required.
PRR—Periodic reauthorization required.
RSL—Restricted supply list.
VLD—Limit on visits per year.
VPD—Limit on visits per day, followed by number of visits.

SOURCE: Health Care Financing Administraion: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

Table 4.9

Medicaid limits on prescribed drugs, by jurisdiction: March 1984

Medicaid jurisdiction[1]	Copayment level	Maximum prescriptions per month	Maximum refills per month(s)[2]	Days elapsed before refill[3]	Over-the-counter exclusions[4]	Formulary status[5]
Alabama	$0.50–$3.00		5/6	34	B	C
Arkansas		4	5/6	33	B	B
California	1.00			100	B	D
Colorado			1/1	100	B	C
Connecticut			[6]16	30	A	A
Delaware					B	A
District of Columbia	0.50		3/4	30	B	B
Florida					B	B
Georgia		6		30	B	C
Hawaii				30–90	A	B
Idaho				34	B	B
Illinois					B	C
Indiana					A	B
Iowa	1.00				B	B
Kansas	1.00		[7]12	30–100	A	A
Kentucky					B	C
Louisiana					B	B
Maine	0.50		5/6	180	B	A
Maryland			2/12	100	B	B
Massachusetts			5/6	30–60	B	B
Michigan	0.50		5/6	120	B	C
Minnesota					B	B
Mississippi		4			B	C
Missouri	0.50–2.00	5			B	C
Montana	0.50				B	A
Nebraska					A	C
Nevada	1.00	3	3/1	30	B	B
New Hampshire	0.75		5/6	90	A	C
New Jersey			5/6	60	A	B
New Mexico				180	B	C
New York			5/6		B	D
North Carolina	0.50	6			B	A
North Dakota			5/12		A	A
Ohio			5/12		B	C
Oklahoma		3	3/1	34	B	D
Oregon				100	B	D
Pennsylvania			5/12	34	A	B
Rhode Island			5/12	100	B	B
South Carolina	0.50	3	3/1	90	B	D
South Dakota	1.00				B	B
Tennessee		7	5/12	31	B	D
Texas		3	5/6	180	B	C
Utah					A	C
Vermont	1.00			60	B	C
Virginia	0.50–1.00				B	B
Washington					B	C
West Virginia	0.50–1.00			30	B	C
Wisconsin	0.50	12	11/12	34	B	C

[1] Alaska and Wyoming do not have drug programs.
[2] Number of refills/number of months.
[3] Number of days that must elapse before a single prescription can be refilled.
[4] Over-the-counter (OTC) exclusion codes:
A - All or most OTC drugs reimbursable.
B - Few or no OTC or prescription drugs except insulin reimbursable.
[5] Formulary status codes:
A - No drug list; all legend drugs reimbursable.
B - No drug list; certain categories excluded from reimbursement.
C - Limited drug list.
D - Restricted drug list.
[6] Unlimited refills within 6 months of original prescription date.
[7] Unlimited refills within 12 months of original prescription date.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

number of unduplicated recipients will generally be less than the sum of recipients who receive each service.

Medicaid recipient and service statistics are not presented as rates per 1,000 eligibles (population at risk), as are the Medicare data presented in Chapter 3. Instead, they represent average use by those who actually received services. (No national counts of Medicaid eligibles are available at present, although work is in progress to develop unduplicated counts of eligibles.) The number of recipients in each State Medicaid program in fiscal year 1983 and the percentage of total recipients who used specific services are shown in Table 4.10. Because a recipient can receive more than one service, the sum of individual percentages may exceed 100 percent.

In Table 4.11, the number and percent of Medicaid recipients and the percent of total vendor payments in fiscal year 1983 (excluding territories) are displayed by type of medical service and recipient's age, sex, and race or ethnic origin. Persons under 21 years of age comprised 50.2 percent of total recipients. These individuals were proportionally low users of specific services except for dental (63.8 percent) and clinic (52.3 percent) services. Recipients 21–64 years of age constituted 31.5 percent of all recipients and used proportionately more family planning, laboratory and radiological, and inpatient hospital services. Those 65 years of age or over used proportionately more SNF, ICF, and home health services. Females equaled or exceeded their proportion of the recipient population in the use of virtually every service.

Recipients under 21 years of age accounted for 20.1 percent of total Medicaid payments but 57.2 percent of all payments for dental services. Recipients 21–64 years of age accounted for 77.9 percent of all payments for family planning services, and those aged 65 or over accounted for 83.1 percent of SNF payments and 50.4 percent of ICF payments.

The number of recipients and total days of care in general hospitals, SNF's, and ICF's, along with the number of physician visits and the number of outpatient drug prescriptions for Medicaid recipients, are shown by jurisdiction for fiscal year 1983 in Table 4.12. For general hospitals, total discharges are a count of hospital stays, but recipients discharged are an unduplicated count of persons. A day of care in general hospitals, SNF's, or ICF's is counted only if paid for in whole or in part by Medicaid. As a result, it is not possible to derive average lengths of stay for Medicaid patients from these data alone.

A physician visit is a consultation with a physician or a person acting under the physician's supervision. When a physician's bill does not show visits but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. The number of prescriptions includes refills but covers only drugs dispensed outside hospitals or other inpatient facilities.

Expenditures

In this section, the distribution of Medicaid vendor payments is described by maintenance assistance status, basis of eligibility, and type of service and by age, race or ethnicity, and sex of recipient. In Table 4.13, the distribution of vendor payments is presented by aid category and maintenance assistance status—cash assistance or medical assistance only. Cash assistance recipients accounted for 52.8 percent of total vendor payments; medical assistance recipients, for 47.2 percent. Except for the category 65 years of age or over, cash assistance recipients accounted for the larger share of vendor payments in each eligibility group.

Medicaid expenditures for fiscal year 1983 are displayed by rank of total payments for each jurisdiction and basis of eligibility in Table 4.14. In fiscal year 1983, persons 65 years of age or over accounted for the largest share of total vendor payments (37.0 percent), although this group represented only 15.1 percent of all recipients (Table 4.5). The disabled also accounted for a disproportionate share of total vendor payments (34.6 percent of total vendor payments, as opposed to 13.8 percent of total recipients). In contrast, AFDC recipients, although representing 69.3 percent of all recipients, accounted for only 25.7 percent of total vendor payments.

New York and California combined accounted for 30.3 percent of all vendor payments in fiscal year 1983; the top six States accounted for 48.8 percent of the total. These six States (California, New York, Pennsylvania, Ohio, Michigan, and Illinois) also accounted for 46.4 percent of total recipients.

In Table 4.15, Medicaid programs are ranked by number of recipients and total vendor payments (shown in Tables 4.5 and 4.14, respectively). The two rankings are closely related. The most noticeable exception is Puerto Rico, which ranks third in number of recipients but only 39th in total vendor payments. This inconsistency reflects the congressionally mandated expenditure limit placed on Puerto Rico in 1972.

The distribution of vendor payments in each program is shown in Table 4.16 by age, sex, and race or ethnicity of those receiving services. Medicaid vendor payments by age varied widely across jurisdictions. Greater consistency existed with respect to sex, with females accounting for the larger share of total vendor payments in all jurisdictions.

The distribution of vendor payments across service categories in each Medicaid program is presented in Table 4.17. Among programs reporting for fiscal year 1983, 30.1 percent of all vendor payments went for services in inpatient hospitals (including general and mental hospitals), followed closely by ICF's (29.2 percent) and SNF's (14.3 percent).

In Table 4.18, States are ranked by the ratio of Medicaid recipients to persons living at or below the U.S. poverty level (as defined by the Census Bureau). (It should be noted that persons receiving State-only services are included as Medicaid recipients in Table 4.18.)

Table 4.10

Percent of Medicaid recipients using selected services, by jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Number of recipients in thousands	Type of service: Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory and radiological	Home health	Prescribed drugs	Family planning	Other[1]
		General hospital	Mental hospital		Mentally retarded	All other										
All jurisdictions	21,492.5	17.2	0.4	2.7	0.7	3.7	65.4	23.0	15.4	46.6	8.2	20.8	2.0	63.9	7.2	22.7
Alabama	311.3	21.7	0.0	1.2	0.5	5.4	77.8	13.4	10.3	35.4	0.0	37.0	1.1	71.5	11.2	24.4
Alaska	20.0	14.4	0.0	1.3	0.6	2.7	62.9	15.4	20.5	52.5	5.6	3.6	0.1	0.0	2.1	9.5
Arkansas	190.3	24.4	0.1	3.2	0.7	8.6	80.0	17.3	13.8	41.1	3.1	7.7	1.2	79.5	5.6	26.2
California	3,499.9	14.0	0.1	3.5	0.3	0.3	72.1	28.2	17.0	38.7	5.3	24.8	0.5	63.6	6.6	26.0
Colorado	147.6	16.5	0.5	3.4	1.4	6.6	54.2	18.4	24.2	52.2	39.7	13.2	2.5	70.1	7.9	27.3
Connecticut	215.5	18.0	0.6	8.3	0.6	1.7	66.1	27.6	26.1	55.4	16.1	20.8	1.9	71.3	9.6	23.4
Delaware	45.6	15.7	0.2	0.2	1.1	3.8	75.2	14.2	8.5	49.0	5.3	8.7	1.5	70.0	13.1	7.2
District of Columbia	117.7	13.7	0.2	0.2	0.4	2.1	67.1	11.2	4.2	51.8	7.7	22.3	1.8	58.1	8.6	28.5
Florida	555.2	18.6	0.1	2.4	0.5	4.5	75.3	16.0	10.3	38.4	0.0	13.6	10.6	74.6	4.7	34.6
Georgia	441.1	27.5	0.0	3.7	0.4	4.6	77.4	25.0	10.2	54.8	5.0	10.3	1.7	81.0	9.5	36.3
Hawaii	100.3	14.8	0.0	2.6	0.5	2.4	86.0	40.7	9.2	30.9	7.3	25.5	0.5	75.2	7.1	14.8
Idaho	39.2	15.9	0.0	4.1	1.3	6.4	71.4	19.2	3.6	41.4	0.0	42.6	0.8	71.3	8.1	31.7
Illinois	1,051.0	18.4	0.1	2.1	0.7	4.5	79.3	25.9	16.4	36.5	11.8	22.6	0.5	75.9	11.2	22.5
Indiana	271.7	22.4	0.1	3.7	0.8	10.8	44.5	12.2	18.9	26.6	6.7	6.6	0.7	74.9	3.2	65.5
Iowa	189.5	16.9	0.2	0.2	0.9	10.5	79.7	38.0	23.1	39.1	2.5	8.2	1.4	74.0	10.8	16.9
Kansas	147.2	17.3	0.7	0.6	1.5	10.1	76.0	25.8	16.9	42.3	10.2	22.6	1.2	70.8	9.6	23.0
Kentucky	388.0	19.3	0.1	1.6	0.4	4.3	80.6	21.3	9.2	44.2	9.9	6.7	2.1	64.9	8.0	8.0
Louisiana	378.0	21.2	0.1	0.3	1.5	8.7	76.1	12.4	0.1	44.6	3.5	10.2	0.6	74.9	9.8	31.6
Maine	122.2	26.1	0.0	0.7	0.6	7.4	76.7	23.2	19.8	51.4	4.5	3.9	2.1	69.2	8.2	60.3
Maryland	328.0	16.5	0.0	0.0	0.0	5.3	77.3	24.5	18.4	56.8	0.0	22.4	1.0	70.9	0.0	3.9
Massachusetts	579.1	30.8	0.4	5.1	0.5	5.0	72.1	30.3	23.5	40.6	6.2	16.6	3.6	63.4	1.3	28.1
Michigan	1,187.6	13.0	0.2	1.6	0.3	3.1	72.6	24.7	14.3	37.6	2.4	21.2	0.6	65.2	12.5	23.7
Minnesota	326.4	21.5	0.2	8.4	2.4	5.7	75.3	39.7	18.9	33.8	6.1	4.2	3.6	64.2	8.2	30.2
Mississippi	290.5	22.9	0.0	2.4	0.6	3.1	82.7	24.3	5.0	39.2	0.0	11.6	0.9	80.5	9.5	27.3
Missouri	341.6	21.1	0.1	0.7	0.7	6.9	61.7	26.9	14.6	49.5	27.6	17.1	0.7	69.5	9.0	11.2
Montana	44.8	19.1	0.0	0.5	0.6	10.3	75.8	31.9	23.5	40.7	0.1	5.7	1.2	61.9	5.6	31.1
Nebraska	84.0	18.6	0.4	1.3	1.1	10.6	80.7	27.0	27.0	35.3	1.6	28.3	1.4	71.6	7.1	20.1
Nevada	27.9	26.8	0.1	1.7	0.8	8.3	77.0	19.3	10.1	41.6	2.6	17.8	1.2	68.0	8.5	34.6
New Hampshire	41.7	17.2	0.5	0.5	0.7	12.7	57.9	24.7	18.1	45.7	8.4	9.6	2.7	69.7	7.7	21.9
New Jersey	611.9	15.5	0.4	0.8	0.7	4.2	74.6	32.9	21.7	45.4	7.1	34.5	1.1	80.6	8.7	17.1
New Mexico	84.4	20.8	0.0	0.3	0.7	4.2	71.3	26.3	5.2	40.4	7.8	10.3	1.0	69.1	5.7	27.1
New York	2,160.6	18.8	1.9	3.7	1.1	1.2	61.4	26.6	24.7	49.1	17.0	43.7	9.0	64.1	8.3	20.3
North Carolina	349.1	22.0	0.3	4.0	0.9	3.8	68.3	25.8	11.5	42.8	6.8	25.9	0.9	70.0	7.5	29.5
North Dakota	31.9	27.3	0.6	10.1	0.9	8.0	75.6	33.5	22.0	27.4	6.6	12.4	1.9	64.4	6.8	28.8
Ohio	910.6	17.8	0.1	3.5	0.8	2.9	71.0	29.7	23.6	57.9	11.6	10.8	0.7	73.6	2.5	16.4
Oklahoma	232.5	20.0	0.3	0.0	0.7	9.6	59.0	10.5	3.4	5.7	0.0	0.9	0.0	46.4	1.3	28.0
Oregon	152.1	12.2	0.3	0.6	1.3	7.0	75.6	15.0	13.6	36.6	0.0	0.0	0.3	69.6	7.3	49.7
Pennsylvania	1,167.2	13.7	0.4	3.9	0.8	3.5	55.5	29.4	12.9	53.2	13.7	20.9	0.9	68.8	8.8	17.1

See footnotes at end of table.

Table 4.10—Continued

Percent of Medicaid recipients using selected services, by jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Number of recipients in thousands	Type of service														
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory and radiological	Home health	Prescribed drugs	Family planning	Other[1]
		General hospital	Mental hospital		Mentally retarded	All other										
Puerto Rico	1,547.1	4.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	99.9	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	104.6	15.9	0.1	1.3	1.0	7.3	66.5	26.9	17.6	43.6	0.0	15.4	1.4	72.4	5.3	30.3
South Carolina	236.2	25.7	3.2	2.2	1.1	3.7	73.4	18.0	9.5	41.5	0.0	9.8	0.8	68.6	8.9	19.0
South Dakota	33.5	21.9	0.4	1.3	2.2	15.3	76.7	14.6	9.2	38.0	9.2	11.0	1.5	59.1	5.9	23.3
Tennessee	341.2	26.0	0.5	1.4	0.8	7.3	68.0	13.6	4.5	32.1	14.1	31.1	1.4	72.7	6.0	21.3
Texas	680.1	25.0	0.0	1.0	1.9	10.6	82.0	10.8	22.7	34.0	0.0	36.8	0.3	78.5	7.3	24.9
Utah	66.0	17.4	0.2	0.9	2.0	6.1	81.1	29.5	12.7	39.9	3.8	17.2	0.4	66.2	8.2	17.4
Vermont	53.6	12.1	0.2	0.3	0.7	5.5	77.7	23.1	21.0	45.5	7.3	5.8	3.8	70.7	9.2	24.9
Virgin Islands	11.1	7.6	0.0	0.0	0.0	0.0	1.0	9.0	0.0	80.2	0.0	0.4	0.6	73.0	5.1	17.4
Virginia	306.4	19.0	0.1	0.6	1.5	5.8	79.8	18.0	12.3	47.1	10.6	27.2	0.8	71.8	12.0	19.6
Washington	257.6	14.6	0.2	7.8	1.1	1.8	81.6	20.2	16.7	39.5	0.0	48.6	1.1	71.9	12.5	28.5
West Virginia	177.4	20.3	0.0	0.0	0.1	5.1	76.2	10.5	6.2	33.1	6.2	12.4	0.3	55.7	6.2	33.2
Wisconsin	480.1	11.4	0.3	6.8	0.6	5.0	44.7	28.4	22.4	36.7	45.3	4.3	1.3	66.1	9.5	37.9
Wyoming	14.2	19.7	0.0	1.9	0.0	9.3	82.7	19.2	16.5	43.2	0.0	12.6	0.2	0.0	5.8	12.3

[1] Includes early and periodic screening, diagnosis, and treatment services; rural health care; and other services.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.11

Percent distribution of Medicaid recipients and payments, by age, sex, race or ethnic origin, and type of service: Fiscal year 1983

Type of service	Number of recipients in thousands	Age				Sex		Race or ethnic origin				
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution										
Total	21,492.5	20.7	29.5	31.5	18.3	35.9	64.1	55.8	36.2	1.5	1.0	5.5
Inpatient hospital	3,767.4	12.2	16.8	37.0	34.0	29.6	70.4	50.8	30.3	4.9	4.5	9.5
Skilled nursing facility	573.5	0.8	0.6	12.6	86.0	28.0	72.0	88.5	9.7	0.6	0.6	0.6
Intermediate care facility[1]	943.7	0.5	3.2	22.7	73.6	32.8	67.2	87.7	10.8	0.6	0.3	0.6
Physicians'	14,050.3	21.7	27.3	33.4	17.6	34.7	65.3	55.9	36.1	1.0	1.0	6.0
Dental	4,940.0	15.1	48.7	30.0	6.3	37.5	62.5	54.5	36.9	1.1	1.4	6.2
Other practitioners'	3,305.9	5.9	29.8	38.7	25.6	30.6	69.4	59.6	32.2	1.4	0.6	6.2
Outpatient hospital	10,007.9	22.1	27.4	36.7	13.8	35.1	64.9	52.8	39.6	1.1	0.7	5.8
Clinic	1,760.4	23.3	29.0	39.2	8.5	35.6	64.4	49.4	41.9	1.6	1.2	5.9
Laboratory and radiological	4,461.6	11.5	22.4	43.8	22.3	25.7	74.3	49.5	41.0	0.5	0.9	8.2
Home health	421.8	8.2	5.0	36.0	50.8	28.6	71.4	67.6	28.1	0.7	1.5	2.1
Prescribed drugs	13,725.5	19.8	24.4	34.3	21.5	33.2	66.8	56.6	35.4	1.2	0.9	5.8
Family planning	1,537.6	0.0	34.4	65.6	0.0	2.1	97.9	45.1	48.2	0.8	0.6	5.3
Other	4,868.2	29.7	28.2	18.2	23.8	39.8	60.2	55.9	35.8	2.9	0.7	4.7

Type of service	Payments in millions	Age				Sex		Race or ethnic origin				
		Under 6 years	6–20 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution of payments										
Total	$32,350.5	7.6	12.5	42.8	37.0	34.1	65.9	70.2	25.0	1.3	0.7	2.8
Inpatient hospital	9,734.6	12.9	18.2	48.8	20.1	35.3	64.7	50.7	31.0	5.4	4.9	8.0
Skilled nursing facility	4,621.0	0.7	0.8	15.6	83.1	25.2	74.8	87.7	10.1	0.7	0.9	0.5
Intermediate care facility[1]	9,459.4	0.4	7.9	41.3	50.4	39.4	60.6	85.5	12.9	0.6	0.4	0.5
Physicians'	2,174.6	14.9	20.4	51.5	13.3	30.0	70.0	57.2	34.3	1.5	1.1	5.9
Dental	467.1	12.5	44.7	35.1	7.7	35.4	64.6	55.8	34.0	1.2	2.1	6.8
Other practictioners'	226.2	3.8	25.7	49.0	21.5	33.8	66.2	67.0	24.9	2.7	0.7	4.7
Outpatient hospital	1,544.9	17.7	23.8	48.5	10.0	33.2	66.8	50.1	42.7	1.6	0.7	4.8
Clinic	478.9	11.5	23.3	56.1	9.1	38.2	61.8	54.1	40.6	0.9	0.6	3.7
Laboratory and radiological	183.8	6.9	17.7	58.9	16.5	25.3	74.7	48.9	41.2	0.5	0.7	8.6
Home health	597.2	4.3	4.0	44.8	46.8	25.9	74.1	63.8	32.9	1.0	0.7	1.6
Prescribed drugs	1,771.2	5.5	7.8	41.0	45.8	27.4	72.6	67.5	27.5	0.9	0.5	3.7
Family planning	156.0	0.0	22.1	77.9	0.0	1.8	98.2	45.0	46.9	1.3	0.9	5.8
Other	935.7	10.5	13.5	49.8	26.2	45.4	54.6	65.7	27.6	3.0	0.5	3.2

[1] Figures include intermediate care facilities (ICF's) for the mentally retarded and all other ICF's. Recipients and expenditures for the age category 21–64 years reflect mainly ICF's for the mentally retarded. Recipients and expenditures for the age category 65 years or over reflect mainly all other ICF's.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Average expenditure per Medicaid recipient and average per capita personal income are also reported for each State. The ratio of Medicaid recipients to persons living at or below the poverty level ranged from a low of 17 in South Dakota to a high of 104 in Hawaii. Average expenditures per Medicaid recipient ranged from a low of $793 in West Virginia to a high of $2,897 in New York.

Financing

Under Medicaid, service providers (physicians, pharmacists, hospitals, etc.) are financed by different sources, including:

- The Federal Government, through Federal matching assistance payments.
- The Federal Government, through Medicare Part B (supplementary medical insurance) buy-in agreements.
- State governments.
- Local governments (in some cases).
- Third parties who are liable for care provided to Medicaid eligibles.
- Medicaid recipients themselves.

Data on each source of funds except private third-party payments and expenditures contributed by Medicaid recipients themselves are presented in this section.

Federal and State financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State per capita income, where

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times .45$$

and the Federal share equals 1.00 minus the State share. By design, the formula sets higher rates of Federal matching (up to a statutory maximum of 83 percent) for States with relatively low per capita incomes and lower rates (down to a minimum of 50 percent) for States with relatively high per capita incomes.

The Federal Medicaid assistance percentages (FMAP's) in effect since the enactment of Medicaid are shown in Table 4.19. From fiscal year 1984 to fiscal year 1985, no State received the maximum Federal match of 83 percent; 17 States received the minimum; and Mississippi received the highest, 77.6 percent. These percentages apply to medical vendor payments only.

Although FMAP's are calculated for the territories, the total amount of Federal Medicaid matching funds payable to the territories is limited by law. Under the Deficit Reduction Act of 1984 (Public Law 98-369), the following higher limits applied for fiscal year 1984:

American Samoa	$1,150,000
Guam	2,000,000
Northern Marianas	550,000
Puerto Rico	63,400,000
Virgin Islands	2,100,000

For fiscal year 1984, Federal matching rates for other expenditures were as follows:

- Family planning services were matched at 90 percent.
- Administrative costs were matched at 75 percent. (For States that had a certified Medicaid Management Information System, administrative costs were matched at 50 percent).
- Development of automated claims processing and management information systems was matched at 90 percent, and the operation of such systems was matched at 75 percent.
- Costs of skilled nursing facility inspectors were matched at 75 percent.
- Costs of professional medical personnel used to administer the program were matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent.

The share of total expenditures for medical assistance borne by the States varies with the extent to which States provide medical assistance to State-only eligibles and offer services that do not qualify for Federal financial participation.

Section 2161 of OBRA-81 reduced the total Federal reimbursement for each State by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. The specified reduction was computed on the total Federal Medicaid reimbursement claimed by each State in that year. However, a State can lower its annual reduction rate by 1 percentage point for each of three conditions: operation of a qualified hospital cost review program, an unemployment rate exceeding 150 percent of the national average, and fraud and abuse recoveries (including third-party liability recoveries in fiscal year 1982) equal to 1 percent of Federal payments to the State (42 CFR 433, subpart E).

In addition to the conditions cited previously, section 2161 of OBRA-81 allows for a decrease in the designated reduction in Federal matching dollars for each State that keeps its spending levels within a target rate of growth. For fiscal year 1982, the target level was set at 109 percent (that is, a 9-percent rate of growth) of each State's estimate of the Federal share of its fiscal year 1981 spending level. For fiscal years 1983 and 1984, target levels were based on changes in the medical care component of the Consumer Price Index. In each year, $1 was deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level. (For purposes of calculating the target rates only, section 137 of TEFRA removed the effect of changes in FMAP's for the States after fiscal year 1981.)

Beginning in fiscal year 1983, section 133 of TEFRA requires that Federal matching funds to States with eligibility error rates greater than 3 percent be reduced by the amount of the excess erroneous expenditures. The Secretary of DHHS is permitted to waive the penalty retroactively in certain limited cases based on a determination that the State made a good-faith effort to reduce its error rate to 3 percent. Several factors are considered in calculating the error rate:

- Inclusion of payments to ineligible medical vendors and overpayments to eligible medical vendors.
- Exclusion of technical errors.
- Inclusion of the smaller amount of medical assistance provided, or spend-down and resource errors, or the amount attributed to both.

Total administration and training payments and medical vendor payments subject to FFP, along with the Federal and State share of such payments in fiscal year 1983, are shown in Table 4.20. These expenditure data may differ from expenditure figures in other tables because total payments computable for Federal funding are limited to payments for which FFP is allowed. Payments for which FFP is not allowed, such as Medicare supplementary medical insurance (SMI) premiums paid on behalf of the medically needy, are excluded. The adjusted Federal share reflects accounting adjustments, such as changes in payments to cost-reimbursed providers following yearend audits.

Local funding formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. However, a State plan must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of March 31, 1984, 14 States provided for local funding of the non-Federal share of Medicaid vendor payments. The local funding formulas used by these States in March 1984 are presented in Table 4.21. Formulas range from

Table 4.12

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1983

Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than for mentally retarded)		ICF/MR[3]		Physicians'			Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care	All visits	Rural health visits	Home health visits	
All jurisdictions	3,989,421	2,720,458	30,283,778	573,505	123,114,487	792,682	201,199,267	150,977	43,569,273	89,867,742	201,144	7,069,657	177,436,814
Alabama	53,873	40,254	293,344	3,658	399,531	16,878	4,662,472	1,477	527,743	707,471	4,248	110,603	3,230,037
Alaska	2,429	1,597	26,334	252	25,416	546	123,113	124	40,867	45,657	139	176	0
Arkansas	34,914	24,226	213,438	6,020	1,221,431	16,396	4,388,313	1,420	470,432	665,836	0	9,038	1,262,908
California	457,360	333,620	2,791,340	122,600	23,243,880	10,020	1,086,000	9,960	2,919,180	9,512,920	0	101,740	19,973,640
Colorado	35,389	16,050	147,340	4,991	1,051,409	9,694	2,587,917	2,044	672,932	462,822	2,477	169,484	1,423,486
Connecticut	72,243	37,247	361,373	17,847	4,903,351	3,706	1,040,041	1,368	401,947	483,634	0	671,233	2,236,122
Delaware	7,310	5,856	34,083	112	10,255	1,725	459,736	482	155,391	229,598	0	—	274,607
District of Columbia	24,960	18,311	201,251	226	41,688	2,495	688,454	446	147,224	1,327,174	0	440,346	696,386
Florida	102,237	73,459	647,437	13,134	1,978,550	24,937	5,898,685	2,871	888,578	511,230	0	49,227	6,136,361
Georgia	86,479	60,439	527,186	16,150	3,113,234	20,102	5,278,996	1,795	565,867	1,029,227	10,702	236,687	5,614,945
Hawaii	14,953	10,952	79,132	2,606	298,922	2,378	478,767	504	125,332	461,897	—	7,643	744,585
Idaho	6,398	4,696	23,810	1,620	286,486	2,526	626,162	525	173,853	158,327	470	4,724	280,109
Illinois	224,301	158,790	1,445,358	21,563	4,878,039	47,438	13,782,488	7,783	2,567,431	4,317,048	0	68,619	13,107,776
Indiana	74,614	45,329	430,277	9,941	2,126,992	29,232	7,399,989	2,112	645,889	654,673	0	5,112	3,333,274
Iowa	36,185	25,183	198,573	291	30,694	19,831	5,661,602	1,713	588,563	731,701	1,265	69,556	1,841,500
Kansas	30,589	20,323	175,132	922	110,053	14,915	4,445,794	2,256	855,851	431,821	5	21,155	1,328,482
Kentucky	79,508	54,649	401,994	6,221	636,390	16,618	3,685,834	1,555	424,325	2,280,461	13,287	150,579	2,640,007
Louisiana	151,170	95,353	458,171	1,087	242,299	32,728	11,947,076	5,676	2,517,540	4,205,490	0	45,387	4,791,782
Maine	32,580	23,804	108,286	839	56,189	9,076	2,434,679	676	258,294	425,567	22,888	35,914	1,132,550
Maryland	53,909	41,590	335,456	0	0	18,167	4,674,621	0	0	1,026,255	0	—	2,379,512
Massachusetts	197,387	176,412	3,893,780	29,652	7,390,995	29,142	8,214,058	3,060	953,282	2,897,266	447	415,160	6,438,602
Michigan	177,240	127,619	1,153,651	19,074	2,973,548	37,117	9,307,650	4,017	1,231,799	9,622,062	0	110,550	9,231,695
Minnesota	84,362	54,890	638,252	27,513	6,501,951	18,649	4,147,013	7,739	2,821,577	2,237,310	0	45,425	3,008,976
Mississippi	52,998	39,399	253,886	7,049	1,732,298	8,937	2,363,298	1,629	510,115	853,317	23,044	33,570	3,376,554
Missouri	86,663	57,708	463,512	2,414	164,974	23,687	—	2,518	—	2,358,957	0	44,003	3,190,811
Montana	11,257	6,869	67,415	238	42,605	4,601	1,242,063	269	93,170	379,415	0	—	427,520
Nebraska	16,141	10,737	82,594	1,070	189,975	8,902	2,482,556	943	288,060	693,962	0	46,853	983,093
Nevada	6,130	4,234	44,040	463	44,133	2,315	623,076	218	69,932	117,331	54	4,258	211,540
New Hampshire	7,289	5,114	41,293	200	16,031	5,287	1,523,883	310	92,389	194,125	751	14,929	469,189
New Jersey	113,137	74,911	796,086	4,649	569,365	25,631	7,062,017	4,530	1,297,000	2,769,547	0	436,991	6,566,096
New Mexico	16,529	12,255	18,868	224	27,158	3,510	758,231	617	171,586	324,231	4,783	29,447	633,212
New York	525,403	227,119	6,804,693	80,760	22,267,094	26,548	7,134,330	24,538	3,725,026	12,950,033	0	2,659,022	19,476,001
North Carolina	76,679	75,246	706,608	13,960	2,358,016	13,276	3,368,762	2,997	89,422	1,666,682	29,800	24,646	3,082,491
North Dakota	12,166	6,575	52,541	3,240	717,629	2,555	639,803	302	63,136	101,623	0	1	387,221
Ohio	185,149	133,317	1,200,195	31,887	8,361,978	26,574	7,706,626	6,950	2,294,316	2,616,658	13,277	92,555	9,025,965
Oklahoma	74,940	46,580	415,730	73	4,264	22,390	5,819,670	1,714	596,711	772,361	0	436	1,059,090
Oregon	—	—	—	985	86,705	10,599	3,217,980	1,977	761,718	410,195	—	—	348,195
Pennsylvania	179,774	131,499	1,103,981	45,842	9,882,346	40,702	8,165,151	9,726	3,590,667	2,814,075	—	—	12,023,822
Puerto Rico	85,173	82,881	384,623	0	0	0	0	0	0	4,613,597	0	—	0
Rhode Island	12,011	—	626,837	1,381	94,135	7,676	2,248,442	1,038	362,077	282,923	2,868	23,886	949,839

See footnotes at end of table.

Table 4.12—Continued

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal year 1983

Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than for mentally retarded)		ICF/MR[3]		Physicians'			Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care	All visits	Rural health visits	Home health visits	
South Carolina	41,357	31,678	186,064	5,108	1,074,711	8,772	2,184,461	2,577	842,801	824,823	159	49,117	1,701,540
South Dakota	7,093	4,759	69,013	428	99,378	5,135	1,308,701	729	225,070	233,620	6,323	21,918	275,711
Tennessee	63,450	49,136	246,185	4,620	693,240	25,081	6,222,624	2,597	943,006	677,220	4,645	73,783	4,235,404
Texas	138,865	97,965	836,879	7,103	1,108,520	72,349	19,481,955	13,182	4,451,146	5,360,431	2,925	30,053	6,186,386
Utah	11,838	11,838	76,180	580	74,110	4,023	1,074,792	1,301	437,685	266,950	2,155	12,873	562,611
Vermont	9,261	6,420	60,305	135	12,936	2,961	744,970	383	112,978	419,932	9,582	117,431	454,834
Virgin Islands	961	788	5,883	0	0	0	0	0	0	843	0	811	34,930
Virginia	55,924	41,625	329,007	1,843	267,563	17,806	4,696,200	4,500	1,412,108	1,107,118	0	103,631	3,372,027
Washington	41,300	26,244	213,382	20,115	5,321,445	4,563	1,041,590	2,847	253,910	979,317	2,019	69,886	2,241,395
West Virginia	39,756	29,177	179,131	0	0	9,075	1,476,851	210	133,037	855,826	41,384	18,578	774,000
Wisconsin	74,518	53,464	417,385	32,550	6,329,394	24,095	5,228,151	2,772	798,310	719,320	1,386	391,331	4,279,995
Wyoming	3,269	2,271	16,464	269	53,181	1,316	363,624	0	0	77,863	61	1,290	0

[1] Skilled nursing facility.
[2] Intermediate care facility.
[3] Intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.13

Amount and percent distribution of Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal year 1983

Basis of eligibility	Total payments in millions	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	$32,350.5	52.8	47.2
Age 65 or over	11,953.9	25.1	74.9
Blind	183.1	72.4	27.6
Disabled	11,183.1	61.4	38.6
Dependent children under age 21	3,822.1	84.9	15.1
Adults in families with dependent children	4,483.1	85.8	14.2
Other Title XIX	725.3	NA	100.0

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

that used in Colorado, which requires that the 20 largest counties pay 2 percent of the State share for all new ICF nursing home admissions, to that used in New York, which requires that counties pay 28–50 percent of the State share.

State buy-in with Medicare

If individuals eligible for Medicaid under a State plan also qualify for Medicare SMI coverage, the State can enroll them by paying their SMI premiums. Under this buy-in arrangement, some of the cost of providing care that would otherwise be borne by the State is instead borne by the Federal Government. (A more detailed discussion can be found in Chapter 1.)

The number of individuals enrolled in Medicare SMI under a buy-in arrangement as of calendar year 1983 is shown in Table 4.22. Also included are the number of such individuals receiving reimbursed services and the total payments made under the SMI program on behalf of Medicaid beneficiaries. All but five jurisdictions (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico) buy into the Medicare SMI program.

Administration

Methods of reimbursement and cost containment

Medicaid regulations specify several criteria and methods for reimbursing providers. The method of reimbursement for inpatient hospital services, long-term care services, outpatient hospital services, and physicians' services in 1984 is presented by State in Table 4.23.

Before fiscal year 1982, States were required by law to reimburse inpatient hospital services on the same basis as Medicare, reasonable costs, unless the Secretary of DHHS approved an alternative method of reimbursement. This requirement was dropped by section 2173 of OBRA–81. States are now required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

- Are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards.
- Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, that serve large numbers of low-income patients.
- Provide reasonable access to inpatient hospital services of adequate quality.
- Are routinely documented through uniform cost reports filed by each hospital and through periodic State audits of such reports (42 CFR 447.252).

States must ensure that their payment systems for SNF and ICF services are reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date. For all other services, States are free to choose their own method of payment as long as the aggregate Medicaid payment levels do not exceed the amounts that would be paid under Medicare.

As of March 1984, 16 States reported using Medicare principles for inpatient hospital services, 26 for outpatient hospital services, and 17 States for physicians' services.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. However, the Secretary of DHHS was authorized to waive any Federal Medicaid requirements to enable States to conduct experimental, pilot, or demonstration projects that limit freedom of choice, including prospective reimbursement demonstrations. To provide States more flexibility in implementing various cost-saving measures, section 2175 of OBRA–81 provides that a State will not be held out of compliance for failure to meet certain State plan requirements if it limits free choice in any of the following ways:

- Purchases laboratory services and medical devices through a competitive or other arrangement, if the Secretary finds that adequate services or devices were available to beneficiaries.
- Contracts with organizations that agree to provide services in addition to those offered under the State plan to eligible individuals who reside in the area served by the organization and elect to receive care from the organization.
- Pays for certified rural health clinic services.
- "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period.
- "Locks out" providers who abuse the program, subject to prior notice and opportunity for a hearing and provided that eligible individuals have reasonable access to services of adequate quality.

Table 4.14

Amount and percent distribution of Medicaid payments, by basis of eligibility and jurisdiction, in order by rank: Fiscal year 1983

Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility				
				Age 65 or over	Blind	Disabled	AFDC[1]	Other Title XIX
				Percent distribution				
All jurisdictions	$32,350.5	100.0	100.0	37.0	0.6	34.6	25.7	2.2
New York	6,259.5	19.3	19.3	43.8	0.5	34.5	17.8	3.3
California	3,557.2	11.0	30.3	24.1	1.1	35.2	34.9	4.7
Pennsylvania	1,718.8	5.3	35.6	38.5	0.4	35.9	23.7	1.5
Ohio	1,474.3	4.6	40.2	31.5	0.4	32.0	36.1	0.0
Michigan	1,421.7	4.4	44.6	25.1	0.3	34.1	39.3	1.1
Illinois	1,347.0	4.2	48.8	21.4	0.2	43.1	35.0	0.3
Massachusetts	1,338.2	4.1	52.9	47.3	0.0	31.2	19.2	2.2
Texas	1,316.7	4.1	57.0	44.2	0.7	36.7	18.4	0.1
New Jersey	981.5	3.0	60.0	36.6	0.3	28.5	30.1	4.5
Wisconsin	901.1	2.8	62.8	40.4	0.6	33.2	25.1	0.7
Minnesota	868.1	2.7	65.5	43.6	0.4	36.8	14.8	4.4
Florida	681.3	2.1	67.6	39.4	0.6	36.9	23.0	0.0
Louisiana	674.7	2.1	69.7	37.2	0.7	42.6	18.7	0.8
Georgia	601.4	1.9	71.6	32.1	0.9	39.6	27.2	0.3
Indiana	596.0	1.8	73.8	36.0	0.6	37.8	25.6	0.0
North Carolina	567.0	1.8	75.2	39.4	1.0	32.7	23.7	3.2
Tennessee	508.6	1.6	76.8	36.1	0.8	38.2	24.9	0.0
Connecticut	495.4	1.5	78.3	49.5	0.2	25.9	19.6	4.8
Virginia	488.2	1.5	79.8	44.2	0.5	33.3	21.1	0.9
Missouri	468.5	1.4	81.2	42.5	0.8	30.5	25.7	0.6
Maryland	446.6	1.4	82.6	40.1	0.2	19.7	40.0	0.0
Washington	427.1	1.3	83.9	34.9	0.2	40.0	24.9	0.0
Kentucky	411.0	1.3	85.2	31.6	0.8	35.5	31.2	1.0
Oklahoma	388.7	1.2	86.4	42.3	0.2	24.6	32.7	0.1
Alabama	368.7	1.1	87.5	37.8	0.7	37.7	23.3	0.4
Arkansas	313.2	1.0	88.5	39.3	1.2	40.5	14.9	4.2
Iowa	312.0	1.0	89.5	32.8	0.5	33.2	29.9	3.6
Mississippi	299.4	0.9	90.4	42.7	0.7	31.7	24.0	0.8
South Carolina	278.8	0.9	91.3	38.6	0.7	38.3	22.3	0.0
Colorado	255.3	0.8	92.1	39.1	1.0	35.9	20.5	3.5
Kansas	254.5	0.8	92.9	32.6	0.3	33.0	30.3	3.8
Oregon	236.2	0.7	93.6	32.1	2.8	36.9	26.5	1.6
Rhode Island	221.7	0.7	94.3	46.8	0.4	39.8	12.7	0.3
Maine	205.1	0.6	94.9	44.0	0.2	29.6	25.4	0.8
District of Columbia	196.5	0.6	95.5	28.9	0.1	37.3	33.7	0.0
Nebraska	146.0	0.5	96.0	42.0	0.5	31.3	23.3	2.9
Hawaii	141.7	0.4	96.4	41.1	0.2	22.6	35.7	0.4
West Virginia	140.6	0.4	96.8	39.4	0.3	25.3	34.5	0.6
Puerto Rico	119.8	0.4	97.2	0.0	0.0	5.4	61.7	33.0
Utah	114.5	0.4	97.6	25.0	0.1	39.1	25.9	9.8
New Mexico	101.8	0.3	97.9	25.8	1.4	43.0	28.7	1.1
New Hampshire	93.1	0.3	98.2	62.1	1.6	22.1	14.0	0.1
Montana	86.2	0.3	98.5	41.9	0.5	34.4	22.6	0.5
Vermont	84.3	0.3	98.8	37.4	0.2	39.0	22.6	0.9
North Dakota	83.3	0.3	99.1	56.4	0.2	21.4	17.3	4.8
South Dakota	77.8	0.2	99.3	43.4	0.4	40.0	15.3	0.9
Nevada	73.7	0.2	99.5	32.9	1.7	44.5	19.5	1.4
Idaho	67.3	0.2	99.7	37.6	0.3	40.6	21.0	0.6
Delaware	62.1	0.2	99.9	36.8	0.2	31.5	29.8	1.7
Alaska	51.2	0.2	100.0	28.5	0.2	40.1	19.1	12.0
Wyoming	24.4	0.1	100.0	50.3	0.4	17.0	31.8	0.6
Virgin Islands	2.6	0.0	100.0	16.8	0.0	6.7	68.6	7.9

[1] Aid to Families with Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.15

Medicaid jurisdictions ranked by number of recipients and payments for recipients: Fiscal year 1983

Medicaid jurisdiction	Number of recipients	Amount of payments
	Rank order	
California	1	2
New York	2	1
Puerto Rico	3	39
Michigan	4	5
Pennsylvania	5	3
Illinois	6	6
Ohio	7	4
Texas	8	8
New Jersey	9	9
Massachusetts	10	7
Florida	11	12
Wisconsin	12	10
Georgia	13	14
Kentucky	14	23
Louisiana	15	13
North Carolina	16	16
Missouri	17	20
Tennessee	18	17
Maryland	19	21
Minnesota	20	11
Alabama	21	25
Virginia	22	19
Mississippi	23	28
Indiana	24	15
Washington	25	22
South Carolina	26	29
Oklahoma	27	24
Connecticut	28	18
Arkansas	29	26
Iowa	30	27
West Virginia	31	38
Oregon	32	32
Colorado	33	30
Kansas	34	31
Maine	35	34
District of Columbia	36	35
Rhode Island	37	33
Hawaii	38	37
New Mexico	39	41
Nebraska	40	36
Utah	41	40
Vermont	42	44
Delaware	43	49
Montana	44	43
New Hampshire	45	42
Idaho	46	48
South Dakota	47	46
North Dakota	48	45
Nevada	49	47
Alaska	50	50
Wyoming	51	51
Virgin Islands	52	52

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Additionally, the provision authorizes the Secretary to waive certain State plan requirements for a 2-year period in order to assist States in improving cost effectiveness in various areas of program operation, such as:

- Allowing States to create a primary care case-management system or a physician specialty arrangement.
- Allowing a locality to act as a central broker, helping Medicaid beneficiaries select among competing health plans.
- Permitting States to share with recipients, in the form of additional services, savings resulting from the use of more cost-effective care.
- Restricting the providers from whom recipients can obtain services (in other than emergency situations) to those who agree to comply with reasonable State standards.

Federal regulations governing payments for prescription drugs, known as the maximum allowable cost (MAC) system, went into effect in August 1976 (42 CFR 447.332). MAC regulations place upper limits on government payments for certain multisource prescription drugs and require States to establish estimates of the acquisition cost (known as estimated acquisition cost, or EAC) of all outpatient drug products prescribed for Medicaid enrollees. The exception to this regulation is that a physician may specify in writing that a higher cost drug is required. For Federal matching purposes, payments for prescription drugs may not exceed the MAC limit (plus a reasonable dispensing fee), the EAC estimate (plus a reasonable fee), or the provider's usual and customary charge to the general public, whichever is lowest.

Prior to October 1, 1981, States could enter into prepaid risk contracts only with federally qualified health maintenance organizations (HMO's). Contracting HMO's were required to have an enrollment consisting of less than 50 percent Medicaid and Medicare beneficiaries. Section 2178 of OBRA–81 allows States to enter into prepaid risk contracts not only with qualified HMO's but also with organizations that make covered services accessible to Medicare enrollees to the same extent that these services are accessible to Medicaid recipients not enrolled with the organization and have made adequate provision against the risk of insolvency. Participating organizations also must assure that Medicaid enrollees will not be held liable for debts in the event of the organization's insolvency. Additionally, contracts must provide for:

- Access by the Secretary of DHHS and the State to certain books and records of the HMO.
- Nondiscrimination on the basis of health status or use of health services in the organization's enrollment, reenrollment, and disenrollment activities.
- Disenrollment rights for individuals after 1 full month of membership.
- Reimbursement for medically necessary services received out of plan (under certain circumstances).

Section 2178 also requires States to continue Medicaid eligibility to the end of an HMO's minimum enrollment period for Medicaid-covered HMO enrollees who would otherwise lose their Medicaid eligibility.

Table 4.16

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin				
			Under 20 year	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
			Percent distribution									
All jurisdictions	$32,350.5	$1,505	18.2	41.0	40.8	33.9	66.1	73.7	21.9	0.8	0.6	2.9
Alabama	368.7	1,184	14.9	42.3	42.8	31.0	69.0	58.1	41.8	0.0	0.1	0.0
Alaska	51.2	2,558	33.3	39.2	27.5	40.8	59.2	52.2	5.1	41.0	0.9	0.8
Arkansas	313.2	1,646	18.0	34.2	47.8	34.5	65.5	70.3	29.6	0.0	0.1	0.0
California	3,557.2	1,016	17.8	51.1	31.1	35.4	64.6	—	—	—	—	—
Colorado	255.3	1,729	16.4	41.2	42.4	36.3	63.7	74.4	6.3	0.4	0.3	18.5
Connecticut	495.4	2,299	14.4	33.4	52.3	32.0	68.0	82.4	17.6	0.0	0.0	0.0
Delaware	62.1	1,361	22.7	40.4	36.9	32.4	67.6	58.3	39.2	0.1	0.4	2.0
District of Columbia	196.5	1,670	18.7	49.6	31.7	34.7	65.3	11.0	89.0	0.0	0.0	0.0
Florida	681.3	1,227	18.2	36.7	45.2	30.4	69.6	67.0	31.5	0.0	0.1	1.4
Georgia	601.4	1,363	19.9	40.5	39.7	30.5	69.5	53.8	46.1	0.0	0.0	0.0
Hawaii	141.7	1,413	20.9	37.5	41.6	37.7	62.3	21.3	0.5	0.0	76.9	1.3
Idaho	67.3	1,715	22.2	40.0	37.8	35.6	64.4	94.3	0.4	0.3	2.1	2.8
Illinois	1,347.0	1,282	23.0	49.8	27.2	36.0	64.0	57.0	37.6	0.1	0.4	4.9
Indiana	596.0	2,194	14.0	45.3	40.7	31.2	68.8	80.2	0.9	18.8	0.0	0.1
Iowa	312.0	1,647	21.0	42.2	36.8	35.2	64.8	94.5	4.3	0.3	0.5	0.4
Kansas	254.5	1,729	28.1	39.2	32.7	36.0	64.0	92.7	6.3	0.3	0.0	0.8
Kentucky	411.0	1,059	22.5	42.6	34.8	32.8	67.2	87.0	13.0	0.0	0.0	0.0
Louisiana	674.7	1,785	20.5	41.4	38.1	36.3	63.7	55.6	44.4	0.0	0.0	0.0
Maine	205.1	1,679	15.7	37.4	46.8	33.1	66.9	—	—	—	—	—
Maryland	446.6	1,362	22.4	35.4	42.2	30.6	69.4	56.1	43.9	0.0	0.0	0.0
Massachusetts	1,338.2	2,311	13.3	37.8	48.9	31.7	68.3	—	—	—	—	—
Michigan	1,421.7	1,197	25.1	47.8	27.1	33.5	66.5	68.0	30.4	0.3	0.3	1.0
Minnesota	868.1	2,660	15.1	37.0	47.9	36.9	63.1	94.1	2.3	2.0	1.4	0.3
Mississippi	299.4	1,031	19.1	33.0	47.9	29.1	70.9	45.9	54.0	0.1	0.0	0.0
Missouri	468.5	1,371	13.1	34.8	52.2	31.1	68.9	76.4	23.2	0.1	0.1	0.1
Montana	86.2	1,925	14.9	38.7	46.4	34.9	65.1	89.0	0.2	8.8	1.0	0.9
Nebraska	146.0	1,738	20.3	37.2	42.5	35.0	65.0	85.4	10.6	2.0	0.4	1.6
Nevada	73.7	2,644	24.0	41.6	34.4	36.8	63.2	78.8	14.5	2.5	0.7	3.6
New Hampshire	93.1	2,231	7.8	28.6	63.6	29.0	71.0	—	—	—	—	—
New Jersey	981.5	1,604	22.5	38.0	39.5	32.1	67.9	63.8	27.9	0.0	0.1	8.1
New Mexico	101.8	1,206	21.1	50.0	28.9	35.9	64.1	92.4	3.7	3.9	0.0	0.0
New York	6,259.5	2,897	15.9	32.8	51.3	34.4	65.6	77.6	18.0	0.7	0.6	3.2
North Carolina	567.0	1,624	15.6	45.1	39.3	33.4	66.6	58.9	39.6	0.1	0.0	1.3
North Dakota	83.3	2,610	12.3	31.1	56.7	34.6	65.4	89.6	0.1	9.9	0.2	0.3
Ohio	1,474.3	1,619	22.5	44.4	33.1	32.0	68.0	75.2	24.1	0.0	0.0	0.7
Oklahoma	388.7	1,672	21.6	37.4	41.0	38.4	61.6	82.1	12.0	5.0	0.4	0.6
Oregon	236.2	1,536	18.8	47.0	34.2	34.1	65.9	89.8	5.0	2.1	1.6	1.5
Pennsylvania	1,718.8	1,473	18.1	42.3	39.7	36.5	63.5	77.6	20.0	0.0	0.2	2.2
Puerto Rico	119.8	77	47.0	53.0	0.0	40.1	59.9	0.0	0.0	0.0	0.0	100.0
Rhode Island	221.7	2,119	9.4	40.2	50.4	31.6	68.4	83.6	10.9	0.1	1.6	3.8

See footnote at end of table.

Table 4.16—Continued

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin				
			Under 20 years	21–64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
			Percent distribution									
South Carolina	$278.8	$1,180	17.9	38.7	43.4	29.7	70.3	52.5	47.4	0.0	0.0	0.0
South Dakota	77.8	2,322	17.6	36.3	46.1	37.5	62.5	85.7	0.0	14.3	0.0	0.0
Tennessee	508.6	1,490	20.0	39.2	40.8	32.5	67.5	71.0	29.0	0.0	0.0	0.0
Texas	1,316.7	1,936	16.7	38.7	44.6	33.0	67.0	63.7	20.8	0.0	0.3	15.1
Utah	114.5	1,734	28.7	45.3	26.0	38.7	61.3	91.8	0.8	1.9	0.6	5.0
Vermont	84.3	1,572	18.0	42.7	39.3	34.9	65.1	98.7	0.2	0.1	0.8	0.1
Virgin Islands	2.6	230	43.1	40.1	16.8	30.2	69.8	—	—	—	—	—
Virginia	488.2	1,593	15.6	38.5	45.9	33.5	66.5	61.0	38.3	0.1	0.4	0.2
Washington	427.1	1,658	16.1	48.1	35.8	34.6	65.4	90.4	4.7	2.3	1.0	1.6
West Virginia	140.6	793	20.1	39.8	40.2	29.0	71.0	95.2	4.7	0.0	0.0	0.0
Wisconsin	901.1	1,877	18.8	52.5	28.7	35.0	65.0	86.6	10.1	1.4	0.4	1.6
Wyoming	24.4	1,721	20.9	29.5	49.6	31.4	68.6	91.3	1.9	1.0	0.1	5.6

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.17

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Total payments in millions	Type of service						
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental
		General hospital	Mental hospital		Mentally retarded	All other		
		Percent distribution						
All jurisdictions	$32,350.5	27.2	2.9	14.3	12.6	16.6	6.7	1.4
Alabama	368.7	23.2	0.3	2.6	13.7	29.3	11.7	1.4
Alaska	51.2	27.9	0.0	5.2	16.0	24.7	12.1	1.4
Arkansas	313.2	21.5	0.1	9.9	12.3	28.4	9.1	1.2
California	3,557.2	38.9	1.1	18.9	7.0	0.7	11.9	2.6
Colorado	255.3	16.5	3.3	10.9	17.9	25.3	4.8	1.0
Connecticut	495.4	20.7	3.3	41.6	9.2	5.3	3.9	0.8
Delaware	62.1	24.3	2.7	0.5	15.2	32.2	9.2	0.8
District of Columbia	196.5	31.9	3.9	1.5	6.4	20.9	10.4	0.5
Florida	681.3	30.6	0.8	8.3	10.6	22.5	9.7	1.4
Georgia	601.4	30.5	0.0	11.2	7.7	17.5	9.6	1.8
Hawaii	141.7	22.5	0.0	16.9	8.2	21.5	14.1	4.8
Idaho	67.3	17.6	0.0	11.9	23.2	26.3	6.9	1.2
Illinois	1,347.0	29.4	0.5	7.7	13.3	20.8	7.6	1.6
Indiana	596.0	25.3	0.3	10.6	5.6	33.5	5.7	0.7
Iowa	312.0	22.3	1.0	0.7	18.6	30.8	9.5	3.4
Kansas	254.5	23.7	4.2	0.7	17.7	29.7	7.4	1.5
Kentucky	411.0	27.6	1.2	7.8	8.1	23.7	13.3	1.6
Louisiana	674.7	18.9	0.5	0.9	22.7	30.3	8.4	1.0
Maine	205.1	23.7	0.0	1.4	10.5	39.6	6.2	1.0
Maryland	446.6	34.6	0.0	0.0	0.0	37.6	7.6	1.2
Massachusetts	1,338.2	32.7	1.4	16.2	13.6	15.6	3.3	1.3
Michigan	1,421.7	31.6	2.2	6.7	10.4	18.8	11.4	1.7
Minnesota	868.1	15.7	1.0	30.5	20.3	14.6	5.0	1.5
Mississippi	299.4	25.8	0.0	15.5	7.4	20.3	10.2	2.1
Missouri	468.5	24.3	0.2	1.3	12.2	37.3	5.5	1.8
Montana	86.2	22.4	0.2	1.5	6.4	42.7	7.8	2.8
Nebraska	146.0	20.7	2.8	5.0	14.4	33.4	8.6	1.4
Nevada	73.7	36.6	0.3	2.5	9.2	28.9	9.2	1.5
New Hampshire	93.1	13.3	4.5	1.0	6.2	57.7	2.7	0.7
New Jersey	981.5	24.8	6.2	2.6	14.1	26.4	5.0	2.2
New Mexico	101.8	32.4	0.0	1.6	12.8	21.9	12.4	2.2
New York	6,259.5	27.2	7.7	23.3	12.4	4.3	2.4	0.6
North Carolina	567.0	28.4	1.7	17.0	15.0	16.2	6.7	2.1
North Dakota	83.3	20.3	3.4	32.2	5.7	19.3	6.1	2.2
Ohio	1,474.3	32.7	1.2	15.1	9.5	12.4	7.0	1.4
Oklahoma	388.7	30.9	3.3	0.0	9.5	34.2	8.0	0.8
Oregon	236.2	15.9	3.2	1.3	19.5	26.7	8.7	0.8
Pennsylvania	1,718.8	21.7	6.3	18.7	21.5	15.1	2.1	2.3
Puerto Rico	119.8	37.4	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	221.7	33.2	0.4	1.4	18.5	33.4	2.3	1.1
South Carolina	278.8	22.1	4.0	12.6	16.0	23.1	8.2	1.3
South Dakota	77.8	19.7	3.0	2.0	17.4	36.8	6.2	0.7
Tennessee	508.6	20.0	2.5	3.2	14.2	30.2	8.0	1.1
Texas	1,316.7	20.4	0.0	2.6	19.9	30.8	10.2	0.8
Utah	114.5	25.6	1.9	2.2	20.5	25.2	10.7	1.9
Vermont	84.3	17.8	1.4	0.9	16.3	31.5	6.7	1.2
Virgin Islands	2.6	45.1	0.0	0.0	0.0	0.0	3.5	1.5
Virginia	488.2	21.2	1.0	2.4	18.4	32.7	8.3	1.0
Washington	427.1	18.4	1.2	31.5	19.6	3.0	7.1	1.7
West Virginia	140.6	40.7	0.0	0.0	1.0	36.7	9.1	1.2
Wisconsin	901.1	15.7	1.5	29.2	8.0	19.1	3.7	1.1
Wyoming	24.4	29.7	0.0	6.6	0.0	45.3	9.9	1.7

See footnote at end of table.

Table 4.17—Continued

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	Type of service							
	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
	Percent distribution							
All jurisdictions	0.7	4.8	1.5	0.6	1.8	5.5	0.5	2.9
Alabama	0.4	3.7	0.0	1.8	0.8	8.6	1.6	0.9
Alaska	1.0	8.2	1.2	0.1	0.0	0.0	0.2	2.0
Arkansas	0.4	3.0	0.4	0.2	0.6	9.0	0.3	3.7
California	1.2	5.2	0.9	0.9	0.1	6.0	0.7	4.1
Colorado	1.1	5.5	4.6	0.3	1.3	5.8	0.6	1.2
Connecticut	0.7	5.5	1.2	0.3	1.0	4.3	0.5	1.8
Delaware	0.4	7.0	0.1	0.2	1.3	4.4	1.4	0.2
District of Columbia	0.2	9.3	5.3	0.7	2.1	3.7	0.3	2.8
Florida	0.2	4.1	0.0	0.3	0.9	8.9	0.1	1.5
Georgia	0.4	5.2	1.6	0.1	1.4	10.1	0.7	2.1
Hawaii	0.9	3.3	0.4	0.7	0.3	4.5	0.9	1.0
Idaho	0.2	3.5	0.0	1.7	0.3	3.7	0.6	2.9
Illinois	0.5	3.9	2.2	0.7	0.2	7.2	0.9	3.4
Indiana	1.5	2.5	0.3	0.1	0.3	6.6	0.4	6.5
Iowa	0.9	3.7	0.3	0.1	0.5	6.1	1.0	1.1
Kansas	0.7	3.9	1.1	0.5	0.3	6.3	0.9	1.3
Kentucky	0.5	5.3	3.3	0.1	1.7	4.7	0.7	3.3
Louisiana	0.0	3.3	1.3	0.2	0.2	8.5	0.6	3.3
Maine	0.9	5.7	0.7	0.1	1.5	6.0	0.6	2.1
Maryland	0.6	10.0	0.0	0.5	1.1	6.4	0.0	0.5
Massachusetts	0.4	6.5	1.9	0.2	1.2	3.9	0.2	1.6
Michigan	0.6	3.7	0.1	1.2	0.3	5.5	1.2	4.6
Minnesota	3.1	2.2	0.3	0.0	0.5	3.5	0.4	1.3
Mississippi	0.3	3.4	0.0	0.2	0.5	12.3	0.7	1.0
Missouri	0.6	7.3	2.0	0.4	0.3	5.5	0.6	0.7
Montana	1.7	2.9	0.0	0.1	0.3	4.6	0.4	6.2
Nebraska	1.0	2.3	0.1	0.9	0.8	7.3	0.3	1.0
Nevada	0.5	2.9	0.1	0.2	0.7	3.6	0.6	3.2
New Hampshire	0.5	3.5	2.4	0.1	0.5	4.6	0.3	2.1
New Jersey	0.8	6.6	1.0	0.6	1.6	6.2	0.5	1.4
New Mexico	0.7	5.1	0.5	0.3	0.7	7.4	0.3	1.6
New York	0.4	4.7	2.7	0.5	7.3	2.8	0.3	3.4
North Carolina	0.3	3.0	1.0	0.7	0.5	6.3	0.5	0.7
North Dakota	0.7	1.6	0.9	0.2	0.8	4.8	0.3	1.5
Ohio	1.2	7.9	1.0	0.7	0.1	8.0	0.1	1.6
Oklahoma	0.1	0.3	0.0	0.1	0.0	3.8	0.1	8.9
Oregon	0.6	3.7	0.0	0.0	0.1	6.1	0.4	12.7
Pennsylvania	0.3	3.0	2.5	0.3	0.2	5.1	0.3	0.7
Puerto Rico	0.0	62.6	0.0	0.0	0.0	0.0	0.0	0.0
Rhode Island	0.2	3.6	0.0	0.2	0.2	4.5	0.2	0.9
South Carolina	0.3	3.0	0.0	0.2	0.5	6.6	0.4	1.8
South Dakota	0.3	2.8	1.3	0.2	0.6	4.0	0.3	4.6
Tennessee	0.2	5.1	3.2	1.1	0.7	9.4	0.3	0.8
Texas	0.7	2.4	0.0	1.4	0.1	6.4	0.5	3.9
Utah	0.7	3.1	1.9	0.6	0.2	4.0	0.4	0.9
Vermont	1.2	5.4	9.3	0.1	1.8	4.9	0.4	1.1
Virgin Islands	0.0	27.0	0.0	0.4	1.0	14.2	0.9	6.5
Virginia	0.9	4.4	1.1	0.6	0.6	6.4	0.4	0.7
Washington	0.6	3.8	0.0	1.5	0.7	5.1	0.4	5.3
West Virginia	0.4	2.2	0.5	0.3	0.3	4.2	0.5	2.8
Wisconsin	0.9	4.0	3.7	0.1	0.7	4.6	0.6	7.2
Wyoming	0.7	4.2	0.0	0.3	0.2	0.0	1.0	0.4

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

Table 4.18

Ratio of Medicaid recipients to persons at or below poverty level, payment per recipient, and per capita personal income, by State: Fiscal year 1983

State	Ratio of Medicaid recipients to persons living at or below poverty level[1]	Payment per recipient[2]	Per capita personal income
Average	45	$1,453	$11,000
Hawaii	104	1,413	11,614
California	83	1,016	12,616
Rhode Island	77	2,119	10,751
Michigan	72	1,197	10,942
Massachusetts	69	2,311	12,153
Wisconsin	67	1,877	10,725
Pennsylvania	64	1,473	10,934
New York	60	2,897	12,389
Vermont	60	1,572	9,478
Illinois	58	1,282	12,091
Louisiana	53	1,746	10,211
Maine	53	1,697	9,031
New Jersey	53	1,604	13,169
District of Columbia	51	1,670	15,064
Maryland	50	1,362	12,237
Minnesota	49	2,660	11,155
Ohio	47	1,619	10,667
Connecticut	45	2,299	13,810
Kansas	38	1,729	11,717
Alaska	37	2,558	16,598
Oklahoma	37	1,672	11,247
West Virginia	37	793	8,758
Delaware	36	1,361	11,810
Missouri	36	1,371	10,188
Washington	35	1,658	11,466
Montana	34	1,925	9,544
Iowa	34	1,647	10,754
Kentucky	34	1,059	8,893
Oregon	34	1,536	10,231
Mississippi	33	1,031	7,725
New Hampshire	33	2,231	10,721
Georgia	31	1,363	9,573
South Carolina	30	1,180	8,475
Virginia	29	1,593	11,056
Nebraska	28	1,738	10,641
Tennessee	28	1,490	8,899
Arkansas	27	1,646	8,424
Colorado	27	1,729	12,202
Indiana	25	2,194	9,994
New Mexico	25	1,206	9,135
North Carolina	25	1,624	9,048
Alabama	24	1,184	8,647
Florida	24	1,227	10,907
Nevada	22	2,644	12,022
North Dakota	22	2,610	10,830
Utah	21	1,734	8,820
Texas	20	1,936	11,423
Wyoming	20	1,721	12,211
Idaho	18	1,715	8,937
South Dakota	17	2,322	9,582

[1] Numerators were calculated from data submitted by the States to the Health Care Financing Administration (HCFA). Numerators for 4 States were estimated from 1980 data. Data from Pennsylvania were adjusted because of a sampling problem. Numerators are estimates of total number of persons receiving Medicaid services in each State regardless of whether Federal monies were involved. Denominators were developed from U.S. Bureau of the Census data. Denominators were adjusted to include estimates of nonpoor receiving Medicaid.

[2] This average was calculated by dividing total expenditures, exclusive of non-Medicaid recipient payments, by the total number of Medicaid recipients as reported to HCFA.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of Medicaid Cost Estimates.

It raises the previous enrollment limit from no more than 50 percent to no more than 75 percent Medicare and Medicaid beneficiaries. Section 2178 also allowed the Secretary to modify or waive this last requirement for public HMO's when warranted by special circumstances and when the HMO was making reasonable efforts to enroll individuals from the private sector.

State administration and training

Administration of State Medicaid programs is vested in single State agencies. State plans must designate a medical assistance unit within each agency that is responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires States to establish medical care advisory committees to counsel the Medicaid agency director about health and medical services. These committees must include board-certified physicians and other representatives of the health profession, members of consumer groups, and the director of either the State public welfare department or the public health department (whichever department does not run the Medicaid agency).

Medicaid regulations establish certain standards governing personnel administration in State Medicaid programs. First, each State must employ a merit system of personnel administration. Second, the State plan must offer a training program for agency personnel. This program must include inservice training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of subprofessional staff and unpaid volunteers. Federal financial participation is available to States for administrative and training costs.

Provider participation

In Table 4.24, the number of enrolled and participating physicians and Medicare-Medicaid certified beds in general hospitals, SNF's, ICF's, and ICF's/MR is shown. Providers are certified by each Medicaid program regardless of their participation status. Enrolled physicians are generally defined as physicians who have applied for and received a Medicaid provider number. Participating physicians are defined as enrolled physicians who have submitted at least one claim within the past 12-month period.

Eligibility determination level

States are allowed several options for administering mandatory coverage of Supplemental Security Income recipients:

- Under section 1634 of the Social Security Act, States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration. Under this agreement, the Social Security Administration provides eligibility information to States for the purpose of issuing Medicaid identification cards and maintaining State eligibility files for processing Medicaid claims.

- States electing to extend Medicaid eligibility to SSI recipients can maintain eligibility determinations on a State level.
- States electing the 209(b) option (in which recipients of SSI cash assistance are not automatically eligible for Medicaid) can require cash assistance recipients to make a separate application for Medicaid.

The option chosen by each State is listed in Table 4.25. As of March 1984, 30 States had elected Federal determination, 6 States had elected to extend Medicaid to all SSI recipients but to maintain eligibility determination on a State level, and 14 had elected to retain their 209(b) status.

Medicaid Management Information System

The Social Security Amendments of 1972 authorized 90-percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems and 75-percent matching for the costs of operating such systems.

The Medicaid Management Information System (MMIS) is a general conceptual design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

State progress in developing and implementing MMIS-type systems as of March 1984 is summarized in Table 4.25. Forty-one States had mechanized claims processing and information retrieval systems approved for 75-percent FFP. One State anticipated operation and approval of 75-percent FFP during fiscal year 1985. Three States were in the planning, development, or installation phase, and five States had no active Federal MMIS plan. Statutory authority for MMIS development is section 235 of Public Law 92-603. Regulations are published in 42 CFR 433, subpart C.

Review for fraud and abuse

Under Federal law, a State plan must specify criteria and methods for identifying suspected fraudulent use of the Medicaid program, methods for investigating cases, and procedures for referring suspected fraud to law enforcement officials.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1980 further authorize 90-percent FFP for the establishment and operation of Medicaid fraud control units in each State. Each unit must be a single identifiable entity located outside the Medicaid agency (for example, in the Office of the State's Attorney General). Fraud control units are responsible for investigating and prosecuting (or referring for prosecution) violations of State Medicaid laws, reviewing complaints alleging abuse or neglect of patients, recovering overpayments, and investigating recipient fraud. Staff of such units must include attorneys, auditors, and investigators. To receive FFP at the 90-percent rate, the unit must be certified by the U.S. Department of Health and Human Services. In fiscal year 1985, 36 Medicaid fraud control units were certified.

Analysis of Arizona's health care program

Arizona is the only State that does not have a Medicaid program. In 1982, the Health Care Financing Administration (HCFA) and the State of Arizona agreed to demonstrate and evaluate a new approach to providing health care to eligible low-income persons. The Department of Health and Human Services awards Medicare and Medicaid demonstration projects to test new methods and approaches for providing quality health care while containing costs. The Arizona demonstration, entitled the Arizona Health Care Cost Containment System (AHCCCS), incorporates a number of cost-containment features, as follows:

- Contracts to health care plans are awarded by competitive bidding and are reimbursed on a capitated prepaid basis. Health care plans must provide or arrange to provide all covered services.
- "Gatekeeping" is performed by primary care physicians, who are responsible for either providing or authorizing the services to be reimbursed, including services by specialists.
- Nominal copayments are required to prevent unnecessary utilization.
- Restrictions are employed on choice of plans and providers.
- Capitated Federal financial participation payments are made at 95 percent of the estimated fee-for-service cost for each eligibility group.
- The program was first administered by a private contractor selected by competitive bid. Since April 1984, the State has administered the AHCCCS program.

If AHCCCS is successful, it could serve as a less costly alternative to the acute-care portion of the traditional fee-for-service system in other State Medicaid programs.

The AHCCCS program covers all groups categorically eligible under Medicaid (AFDC and SSI), for whom Arizona receives Federal matching funds. The program also covers persons not categorically eligible, for whom there are no matching funds: the medically indigent with incomes less than $2,500 and the medically needy with incomes of $2,500–$3,200.

The program does not provide ICF, SNF, home health, nurse-midwife, family planning, and chronic

Table 4.19

Federal Medicaid assistance percentages, by jurisdiction: 1966–85

Medicaid jurisdiction	Jan. 1. 1966–June 30, 1967	July 1, 1967–June 30, 1969	July 1, 1969–June 30, 1971	July 1, 1971–June 30, 1973	July 1, 1973–June 30, 1975	July 1, 1975–Sept. 30, 1977	Oct. 1, 1977–Sept. 30, 1979	Oct. 1, 1979–Sept. 30, 1981	Oct. 1, 1981–Sept. 30, 1983	Oct. 1, 1983–Sept. 30, 1985
Alabama	79.85	78.00	78.54	78.43	75.93	73.79	72.58	71.32	71.13	72.14
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona[1]	63.94	64.99	66.42	64.15	61.92	60.48	60.81	61.47	59.87	61.21
Arkansas	81.67	79.81	79.76	79.42	76.31	74.60	72.06	72.87	72.16	73.65
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.08	55.31	56.24	57.61	57.22	54.69	53.71	53.16	52.28	50.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	65.21	65.09	64.10	60.67	60.95	57.34	56.65	58.94	57.92	58.41
Georgia	74.91	72.85	71.48	69.67	66.96	66.10	65.82	66.76	66.28	67.43
Guam	55.00	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	52.97	50.00	50.75	50.83	50.00	50.00	50.00	50.00	50.00	50.00
Idaho	70.73	67.87	68.91	71.56	69.50	68.18	63.38	65.70	65.40	67.28
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	55.77	53.39	52.85	55.05	57.01	57.47	57.86	57.28	56.73	59.93
Iowa	60.39	59.60	55.27	58.07	59.72	57.13	51.96	56.57	55.35	55.24
Kansas	61.45	57.90	57.78	59.06	55.37	54.02	52.35	53.52	52.50	50.67
Kentucky	76.70	75.25	74.30	73.49	72.12	71.37	69.71	68.07	67.95	70.72
Louisiana	76.41	74.58	73.57	73.49	72.80	72.41	70.45	68.82	66.85	64.45
Maine	69.57	69.92	68.33	69.43	70.03	70.60	69.74	69.53	70.63	70.63
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	50.00	51.62	51.75	53.56	50.13
Michigan	50.31	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.70
Minnesota	60.46	58.40	56.95	56.82	57.37	56.84	55.26	55.64	54.39	52.67
Mississippi	83.00	83.00	83.00	83.00	80.55	78.28	78.09	77.55	77.36	77.63
Missouri	53.90	58.40	59.29	59.53	59.94	58.98	60.66	60.36	60.38	61.40
Montana	62.86	64.01	64.72	67.16	66.08	63.21	61.10	64.28	65.34	64.41
Nebraska	60.39	60.48	57.25	58.48	57.86	55.59	53.46	57.62	58.12	57.13
Nevada	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Hampshire	61.31	60.12	59.18	59.36	62.05	60.28	62.85	61.11	59.41	59.45
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	70.73	70.15	71.48	72.63	72.01	73.29	71.84	69.03	67.19	69.39
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.88	50.00
North Carolina	75.58	75.30	73.96	72.84	70.01	68.03	67.81	67.64	67.81	69.54
North Dakota	66.67	70.74	70.48	71.28	70.12	57.59	50.71	61.44	62.11	61.32
Ohio	52.33	52.64	52.42	53.65	53.59	53.39	55.46	55.10	55.10	55.44
Oklahoma	70.32	69.61	68.84	69.02	68.07	67.42	65.42	63.64	59.91	58.47
Oregon	54.12	54.37	56.35	57.39	59.40	59.04	57.29	55.66	52.81	57.12
Pennsylvania	54.38	55.03	54.60	55.45	55.14	55.39	55.11	55.14	56.78	56.04
Puerto Rico	55.00	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00

See footnotes at end of table.

Table 4.19—Continued

Federal Medicaid assistance percentages, by jurisdiction: 1966–85

Medicaid jurisdiction	Jan. 1, 1966–June 30, 1967	July 1, 1967–June 30, 1969	July 1, 1969–June 30, 1971	July 1, 1971–June 30, 1973	July 1, 1973–June 30, 1975	July 1, 1975–Sept. 30, 1977	Oct. 1, 1977–Sept. 30, 1979	Oct. 1, 1979–Sept. 30, 1981	Oct. 1, 1981–Sept. 30, 1983	Oct. 1, 1983–Sept. 30, 1985
Rhode Island	56.13	52.61	51.70	50.26	55.37	56.55	57.00	57.81	57.77	58.17
South Carolina	81.30	80.50	78.68	78.00	75.00	73.58	71.93	70.97	70.77	73.51
South Dakota	71.05	73.26	69.91	69.69	70.25	67.23	63.80	68.78	68.19	68.31
Tennessee	76.86	76.14	74.62	74.35	72.28	70.43	68.88	69.43	68.53	70.66
Texas	67.27	67.10	65.66	65.18	63.53	63.59	60.66	58.35	55.75	54.37
Utah	66.30	65.24	68.23	69.88	69.95	70.04	68.98	68.07	68.64	70.84
Vermont	68.44	69.00	64.96	64.71	65.38	69.82	68.02	68.40	69.37	68.59
Virgin Islands	55.00	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	66.96	65.85	65.04	64.03	61.58	58.34	57.01	56.54	56.74	56.53
Washington	50.81	50.00	50.00	50.00	53.13	53.72	51.64	50.00	50.00	50.00
West Virginia	74.27	75.84	75.73	76.97	73.52	71.90	70.16	67.35	67.95	70.57
Wisconsin	57.60	56.68	55.21	56.28	60.02	59.91	58.53	57.95	58.02	56.87
Wyoming	55.47	59.20	60.38	62.73	60.99	60.94	53.44	50.00	50.00	50.00

[1] Not applicable; no Title XIX program in effect.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of State Agency Financial Management.

Table 4.20

Medicaid payments eligible for Federal financial participation, by type of payment and jurisdiction: Fiscal year 1983

Medicaid jurisdiction	All payments	Type of payment: Medical assistance: Total computable	Medical assistance: Adjusted Federal share	Medical assistance: State share	Administration and training: Total computable	Administration and training: Adjusted Federal share	Administration and training: State share
		Amount in millions					
United States	$34,685	$33,143	$18,351	$14,792	$1,542	$924	$618
Alabama	358	345	246	99	13	9	4
Alaska	55	52	27	25	2	1	1
Arkansas	338	326	236	91	12	7	5
California	4,084	3,841	1,928	1,913	243	144	99
Colorado	278	266	139	126	13	9	4
Connecticut	529	507	254	253	21	12	9
Delaware	65	62	31	31	3	2	1
District of Columbia	259	245	122	122	14	8	6
Florida	756	721	418	303	36	23	12
Georgia	644	627	417	211	17	11	6
Hawaii	149	143	72	71	7	4	2
Idaho	71	67	44	23	4	3	1
Illinois	1,533	1,477	743	734	57	33	24
Indiana	621	600	340	259	22	13	9
Iowa	332	321	179	142	11	7	4
Kansas	268	258	136	122	10	6	4
Kentucky	474	452	295	158	22	14	8
Louisiana	643	619	413	205	24	14	10
Maine	214	205	145	60	9	5	3
Maryland	590	563	282	281	27	15	12
Massachusetts	1,405	1,366	733	633	38	21	17
Michigan	1,553	1,484	746	738	69	42	27
Minnesota	910	879	479	400	31	17	14
Mississippi	323	315	244	71	8	5	3
Missouri	505	491	297	194	14	8	6
Montana	120	114	75	39	6	3	2
Nebraska	164	156	91	65	8	5	3
Nevada	80	74	37	37	5	3	2
New Hampshire	102	97	58	39	5	3	2
New Jersey	1,039	1,000	502	498	39	27	12
New Mexico	111	104	71	33	7	5	2
New York	6,429	6,140	3,130	3,009	289	168	121
North Carolina	608	574	390	184	34	19	15
North Dakota	90	84	53	32	6	3	2
Ohio	1,518	1,471	816	654	47	26	21
Oklahoma	435	401	240	160	34	20	14
Oregon	253	224	119	106	29	17	12
Pennsylvania	1,857	1,773	1,009	764	85	50	34
Rhode Island	227	220	127	93	7	4	3
South Carolina	304	292	207	85	12	7	5
South Dakota	82	79	54	25	3	2	1
Tennessee	502	487	336	151	15	10	5
Texas	1,502	1,412	789	623	90	57	33
Utah	138	126	87	40	12	8	4
Vermont	88	82	56	26	6	4	2
Virginia	514	491	280	212	22	13	9
Washington	447	425	213	211	22	14	8
West Virginia	156	147	100	47	9	6	3
Wisconsin	938	915	532	383	24	15	9
Wyoming	25	24	12	12	1	1	0

SOURCE: Health Care Financing Administration, Bureau of Program Operations: HCFA–64 Quarterly Report.

Table 4.21

Local funding formulas for Medicaid vendor payments, by State: March 1984

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF[1] nursing admissions.
Florida	Counties pay: 35 percent of cost or $55/mo., whichever is less, for each nursing home resident; 35 percent of cost for 13th–45th inpatient hospital days; 100 percent of State share for first $101–$499 of outpatient service expense for each recipient.
Iowa	Counties match Federal funds for ICF's/MR.[2]
Minnesota	Counties pay 10 percent of State share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 14 percent of State share.
New Hampshire	Local contributions of approximately 25 percent of nursing home costs, excluding residents in State institutions.
New York	Counties pay 50 percent of State share except for certain long-term care services, for which they pay 28 percent of State share.
North Carolina	Counties pay 15 percent of State share for all services except SNF's[3] and ICF's, for which they pay 35 percent of State share.
North Dakota	Counties pay 15 percent of State share except for ICF's/MR, clinic services, and waivered home and community-based services for recipients of services for the mentally retarded.
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee.
South Dakota	$60 per month for each ICF/MR resident and local school district for Crippled Children's Hospital.
Utah	Local contribution of less than 1 percent for specific services such as mental health.
Wisconsin	Local contribution of 10–20 percent for specific services such as mental health.

[1] Intermediate care facility.
[2] Intermediate care facilities for the mentally retarded.
[3] Skilled nursing facilities.

NOTE: Table includes all States with local funding formulas.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

mental health care services. It does provide the following:

- Inpatient hospital services.
- Physicians' services.
- Outpatient hospital services.
- Laboratory and X-ray services.
- Medical supplies, medical equipment, and prosthetic devices.
- Pharmacy services.
- Emergency services.
- Emergency ambulance and medically necessary transportation.
- Emergency dental care and extraction.
- Early and periodic screening, diagnosis, and treatment services for individuals under 18 years of age.
- Medically necessary dentures.
- Orthognathic surgery for children under 18 years of age.
- Podiatry services.

The data presented in Table 4.26 are from the evaluation report of the cost of AHCCCS during its first 2 years (Trapnell et al., 1986). In the report, the cost of the AHCCCS program is compared with that of the traditional fee-for-service Medicaid program. The cost of a fee-for-service program in Arizona was estimated by using actual data on the cost of the same services provided to comparable beneficiaries by Medicaid programs during fiscal years 1983 and 1984. For example, in fiscal year 1983, the estimated Medicaid average recipient cost per month was $78.96, and the estimate of person-months of Federal eligibility was 979,561. The product, $77.3 million, is the estimated cost for Medicaid. This retrospective approach is the most appropriate approach for measuring possible savings achieved by the program. Detailed methodologies used to project costs for Arizona are described in the evaluation report. In estimating the cost of the AHCCCS program, the conceptual basis, methodology, and underlying assumptions used to estimate both traditional Medicaid program costs and actual program costs were taken into account.

The authors of the evaluation report were cautiously optimistic about AHCCCS program savings. AHCCCS program costs and the estimated costs of a traditional Medicaid program in Arizona for fiscal years 1983 and 1984 are presented by eligibility category in Table 4.26. The total program costs incurred for fiscal years 1983 and 1984 were $79.1 million for AHCCCS, and an estimated $87.8 million for a traditional Medicaid program.

In fiscal year 1983, the first year of AHCCCS, the cost of the program was $1.8 million more than the cost of a traditional Medicaid program, representing a 2.3-percent loss. Losses during the first year of the program were largely attributed to administrative difficulties that resulted in delays in enrolling eligibles into prepaid health plans. A large proportion of enrollees were therefore covered under the fee-for-service system. Fee-for-service costs for noncapitated recipients were much higher than originally anticipated. In fiscal year 1984, the AHCCCS program saving was $3.2. million; it cost 3.5 percent less than a traditional Medicaid program.

The AHCCCS program had net savings of $1.4 million during its first 2 years. Program savings were not consistent across eligibility categories. For fiscal year 1984, there were program savings for the aged, disabled, and AFDC categories. There were program

Table 4.22

Medicaid eligibles enrolled as Medicare buy-ins, persons served, and reimbursements, by jurisdiction: Calendar year 1983

Medicaid jurisdiction	Number of State buy-ins enrolled in thousands	Number of persons with reimbursed services[1] in thousands	Total reimbursements in millions
All jurisdictions	3,058.4	2,392.3	$2,707.5
Alabama	115.6	83.1	61.2
Alaska[2]	0.0	1.3	1.7
Arkansas	71.7	53.0	43.3
California	621.3	515.6	800.9
Colorado	36.9	30.0	29.0
Connecticut	13.2	10.9	12.8
Delaware	4.1	3.1	3.2
District of Columbia	13.9	11.0	20.6
Florida	144.3	115.3	162.0
Georgia	130.3	99.9	86.2
Guam	0.6	0.3	0.5
Hawaii	11.3	9.4	11.1
Idaho	7.4	5.9	4.1
Illinois	50.2	40.7	54.6
Indiana	47.1	39.5	33.3
Iowa	35.7	26.9	18.9
Kansas	29.3	22.7	18.3
Kentucky	64.2	41.3	26.0
Louisiana[2]	0.0	1.1	1.2
Maine	16.6	12.6	9.5
Maryland	47.6	39.5	50.8
Massachusetts	88.2	69.3	77.3
Michigan	72.3	56.0	68.1
Minnesota	17.4	13.4	11.5
Mississippi	95.5	69.9	49.6
Missouri	52.3	37.7	27.0
Montana	8.8	6.9	5.5
Nebraska	7.8	5.9	5.3
Nevada	5.9	5.2	7.9
New Hampshire	3.3	2.5	2.0
New Jersey	81.2	67.9	91.8
New Mexico	19.6	14.1	13.6
New York	211.7	171.9	211.9
North Carolina	69.0	55.2	51.2
North Dakota	3.7	2.9	2.2
Ohio	93.5	80.8	79.1
Oklahoma	42.6	30.3	22.8
Oregon[2]	0.0	1.0	1.1
Pennsylvania	95.3	66.2	85.7
Puerto Rico[2]	0.0	1.0	1.2
Rhode Island	10.2	7.9	7.0
South Carolina	70.1	49.1	32.0
South Dakota	5.7	3.6	2.6
Tennessee	89.3	61.2	49.3
Texas	249.8	194.6	210.3
Utah	7.7	6.3	5.6
Vermont	6.4	4.6	3.2
Virgin Islands	0.8	0.2	0.1
Virginia	67.6	53.7	54.2
Washington	47.5	38.3	36.6
West Virginia	23.4	15.1	12.1
Wisconsin	48.8	35.4	30.3
Wyoming[2]	0.0	0.2	0.2

[1] Based on supplementary medical insurance bills (physicians', outpatient services, home health services, and other suppliers of services) paid January 1982–March 1983. Recipient counts and reimbursements correspond to State of residence at the time the bill was processed, which need not be the State which bought in for that person.

[2] No buy-in agreement; therefore, the number of State buy-ins enrolled at any time is zero. It should be noted, however, that recipient counts and reimbursement counts are attributed to the persons's State of residence at the time the bill was processed.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Data from the Division of Entitlement Requirements.

losses for the blind for both years and losses for AFDC recipients in fiscal year 1983.

In summary, data indicate that the AHCCCS program was less costly in the first 2 years of operation than a traditional Medicaid program would have been. These results are encouraging, as program savings were shown even though AHCCCS experienced higher initial startup costs than anticipated.

Medicaid data system

The majority of Medicaid data presented in this report came from a compilation of the annual and monthly Medicaid reports (HCFA–2082 and HCFA–120 reports) submitted to HCFA by the State Medicaid agencies as of August 23, 1984. States obtained this information from their own Medicaid claims processing and payment operations.

The major claims processing and payment system used in the States is the Medicaid Management Information System. The general system design for State systems, completed and distributed by HCFA in 1972, allows for considerable variation in certain MMIS characteristics. This flexibility is congruent with the program diversity existing among the States.

Creating standardized reports for systems employing nonstandard coding, processing, and file structures is obviously difficult. Compounding these difficulties is the programmatic diversity inherent in Medicaid itself. For example, the cross-country variation inherent in the New York State program leads to considerable problems in the creation of a State-level report. As a consequence of these and other factors, approximately six States do not file an annual report in any year. In any month, approximately two States do not file a monthly report. Historically, data for nonreporting States have been estimated by using weighted linear extrapolation methods and aggregating data from other reports. It should be noted that, on several occasions, information supplied by the States in subsequent years has been used to refine or correct data for previous years or provide missing data. Hence, data contained in this report may differ from those published previously.

Deficit Reduction Act of 1984

Several changes in Medicaid law were made by the Deficit Reduction Act of 1984 (DEFRA). This act (Public Law 98–369) became effective on July 18, 1984. For this summary, "prior law" refers to statutes and regulations in effect until the sections of DEFRA became effective. All section references pertain to sections in DEFRA.

Medicaid coverage for children and pregnant women (section 2361)

Under prior law, States were required to provide Medicaid coverage to poor women and children receiving cash assistance under the Aid to Families with Dependent Children program. States had the option of

Table 4.23

Medicaid reimbursement methods, by type of service and jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services[1]				Outpatient hospital services		Long-term care[2]			Physicians' services		
	Medicare principles	Medicaid only	Medicaid and private payers	All payers	Medicare principles	Other	SNF	ICF	ICF/MR	Medicare principles (percent under prevailing charge)	Fee schedules	
											Fixed fee schedule	Relative value scale
Alabama		1981			X		PFS	PFS	PFS	75		
Alaska		1983				X	PFS	PFS	PFS	80		
Arkansas		1984				X	PC	PC	COM		X	
California		[3]1982				X	PC	PC	PC			X
Colorado		1977			X		PFS	PFS	PFS			X
Connecticut	X					X	PFS	PFS	PFS		X	
Delaware	X				X		PFS	PFS	PFS	75		
District of Columbia		1983			X		PFS	PFS	PFS		X	
Florida		1981				X	PC	PC	PC			X
Georgia		1983			X		PFS	PFS	PFS		X	
Hawaii	X					X	RFS	RFS	RFS	80		
Idaho		1980			X		PFS	PFS	PFS		X	
Illinois		1983				X	PFS	PFS	PFS		X	
Indiana	X					X	PFS	PFS	PFS	75		
Iowa		1982			X		RFS	PFS	PFS	75		
Kansas					X		PFS	PFS	PFS	75		
Kentucky		1982				X	PFS	PFS	PFS	75		
Louisiana	X				X		PC	PC	PC	75		
Maine	X				X		COM	PFS	PFS		X	
Maryland				[4]1977		X	COM	COM	COM		X	
Massachusetts			[5]1982			X	RFS	RFS	COM			X
Michigan		1980				X	PFS	PFS	RFS		X	
Minnesota		1983				X	PFS	PFS	RFS		X	
Mississippi		1981			X		PFS	PFS	PFS		X	
Missouri		1981				X	PFS	PFS	PFS		X	
Montana	X				X		PFS	PFS	PFS		X	
Nebraska		1982				X	PFS	PFS	PFS		X	
Nevada		1983				X	COM	COM	COM		X	
New Hampshire	X				X		RFS	PFS	PFS		X	
New Jersey				1979		X	PFS	PFS	RFS		X	
New Mexico	X				X		RFS	RFS	RFS	75		
New York				1983		X	PC	PC	PC		X	
North Carolina		1981			X		PFS	PFS	PFS		X	
North Dakota	X				X		COM	COM	COM		X	

Table 4.23—Continued

Medicaid reimbursement methods, by type of service and jurisdiction: March 1984

Medicaid jurisdiction	Inpatient hospital services[1]				Outpatient hospital services		Long-term care[2]			Physicians' services		
	Medicare principles	Medicaid only	Medicaid and private payers	All payers	Medicare principles	Other	SNF	ICF	ICF/MR	Medicare principles (percent under prevailing charge)	Fee schedules: Fixed fee schedule	Fee schedules: Relative value scale
Ohio	X				X		COM	COM	COM	75		
Oklahoma		1983				X	PC	PC	PC	75		
Oregon		1983			X		RFS	RFS	RFS	75		
Pennsylvania		[6]1983				X	RFS	RFS	RFS		X	
Rhode Island			[7]1977			X	PFS	PFS	RFS		X	
South Carolina	X					X	PFS	PFS	RFS		X	
South Dakota	X				X		PFS	PFS	PFS	75		
Tennessee		1983			X		RFS	PFS	PFS	75		
Texas	X				X		PC	PC	PC	75		
Utah		1983			X		PC	PC	PC		X	
Vermont		1982			X		PC	PC	RFS		X	
Virginia		1982			X		PFS	PFS	PFS		X	
Washington		1982				X	PFS	PFS	PFS			X
West Virginia	X					X	PFS	PFS	PFS		X	
Wisconsin		1981			X		PFS	PFS	PFS		X	
Wyoming	X				X		PFS	PFS	PFS	75		

[1] Year of implementation of alternative reimbursement system.
[2] Facilities: SNF—skilled nursing facility; ICF—intermediate care facility; ICF/MR—intermediate care facility for the mentally retarded.
Reimbursement methods: PFS—prospective facility-specific; RFS—retrospective facility-specific; PC—prospective class rate; COM—combination of other methods.
[3] Combination of retrospective system and contracting system.
[4] Per diem reimbursement based on approved hospital department rates. Payment made as a percent of predetermined charge rates.
[5] Not technically an all-payer system. Medicare does not participate in all-payer system for chronic hospitals. System is based on per diem rate of increase control.
[6] Cost-related with a maximum 10 percent cap on annual increases.
[7] Prospective facility-specific subject to Maxicap. State hospitals reimbursed using Medicare principles.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

Table 4.24

Enrolled and participating physicians and Medicaid-certified beds, by type of provider and jurisdiction: March 1984

Medicaid jurisdiction	Physicians		Certified beds							
					SNF[1]			ICF for mentally retarded	SNF–ICF	
	Enrolled	Participating	General hospital	Swing-beds	Medicaid certified	Dually certified	ICF[2]		Medicaid certified	Dually certified
United States	470,591	249,258	1,004,650	5,695	155,248	323,602	594,244	120,187	69,513	230,973
Alabama	5,000	4,500	21,166	—	86	10,232	5,941	1,523	0	5,011
Alaska	450	—	1,123	0	0	0	0	132	0	542
Arkansas	5,073	2,805	—	0	12,568	481	7,669	1,415	0	0
California	62,453	26,426	93,198	—	16,052	84,161	2,088	464	0	2,690
Colorado	6,223	6,223	13,366	0	5,035	6,344	5,842	2,140	0	11,379
Connecticut	4,238	3,415	11,332	0	—	—	4,000	1,500	—	—
Delaware	800	—	2,163	0	59	0	2,485	562	0	402
District of Columbia	3,134	1,573	5,456	0	953	0	3,854	516	0	763
Florida	15,282	10,000	62,364	796	0	0	1,420	2,961	36,895	0
Georgia	14,152	7,436	25,438	0	28,534	27,853	4,622	2,344	0	32,475
Hawaii	4,779	4,779	2,752	53	910	609	0	361	0	1,022
Idaho	3,589	1,430	3,416	—	0	0	119	560	0	4,530
Illinois	20,905	—	57,500	—	0	194	36,443	4,272	0	47,415
Indiana	11,348	5,027	25,275	0	425	9,346	37,457	2,194	0	0
Iowa	5,899	4,023	22,000	—	44	528	30,850	1,926	0	70
Kansas	4,673	1,235	634	28	73	—	282	24	—	—
Kentucky	13,102	5,210	18,103	0	0	3,769	14,775	1,501	0	30
Louisiana	8,704	5,510	22,840	267	0	0	28,796	5,918	0	3,101
Maine	3,066	1,652	4,586	0	0	416	9,115	722	0	0
Maryland	9,667	5,077	20,224	0	0	10,680	10,937	2,755	0	271
Massachusetts	7,845	—	26,940	0	13,255	5,844	27,052	140	0	0
Michigan	14,836	—	[3]39,745	0	11,285	17,978	8,893	4,525	0	7,396
Minnesota	11,435	5,685	20,802	—	23,986	4,853	17,368	7,634	—	—
Mississippi	5,082	2,838	13,007	40	1,988	0	1,552	1,577	10,149	520
Missouri	15,889	5,983	28,693	224	0	221	9,231	1,630	5,277	16,093
Montana	1,583	1,451	3,232	0	480	2,833	3,012	307	0	4,380

Table 4.24—Continued

Enrolled and participating physicians and Medicaid-certified beds, by type of provider and jurisdiction: March 1984

Medicaid jurisdiction	Physicians		Certified beds							
					SNF[1]			ICF for mentally retarded	SNF–ICF	
	Enrolled	Participating	General hospital	Swing-beds	Medicaid certified	Dually certified	ICF[2]		Medicaid certified	Dually certified
Nebraska	4,500	3,600	9,370	112	0	308	16,433	994	0	434
Nevada	3,978	1,516	3,611	65	0	171	340	187	0	1,988
New Hampshire	1,486	1,404	3,677	11	0	201	6,192	464	0	0
New Jersey	30,991	9,057	32,698	[4]2,876	167	0	2,999	3,422	17,192	11,456
New Mexico	3,847	1,542	4,361	82	0	347	4,432	661	0	—
New York	32,934	29,714	74,597	0	229	72,762	24,737	17,938	0	0
North Carolina	7,119	3,624	23,953	85	528	9,597	11,549	2,819	0	0
North Dakota	1,920	658	3,953	630	4,617	3,225	2,150	531	0	4,617
Ohio	21,121	14,967	49,277	0	0	467	26,853	7,328	0	43,768
Oklahoma	5,200	5,200	—	0	82	0	28,761	1,914	0	0
Oregon	4,568	4,568	11,047	0	918	1,000	10,682	2,131	0	0
Pennsylvania	18,454	13,013	68,307	0	7,240	39,316	30,329	8,844	0	—
Rhode Island	1,588	1,588	4,796	0	0	2,286	6,975	1,095	0	0
South Carolina	4,682	3,920	11,800	0	52	162	4,185	2,633	0	7,490
South Dakota	800	600	3,652	164	4,155	0	3,460	792	0	183
Tennessee	4,170	2,984	27,882	10	0	1,379	22,999	2,471	0	2,220
Texas	26,001	13,446	72,369	72	10,184	2,538	82,339	3,952	0	—
Utah	3,149	3,101	5,365	—	0	0	2,561	1,298	0	2,633
Vermont	1,200	800	2,000	0	78	664	2,320	399	0	0
Virginia	7,911	7,476	23,227	0	0	2,136	20,288	3,574	0	0
Washington	11,263	5,371	—	37	11,265	83	1,384	2,993	0	12,527
West Virginia	3,626	2,802	—	0	0	10	3,829	167	0	3,502
Wisconsin	10,279	5,432	21,624	137	0	554	4,197	3,977	—	504
Wyoming	597	597	1,729	6	0	54	447	0	0	1,561

[1] Skilled nursing facility.
[2] Intermediate care facility.
[3] Excludes State and Federal institutions.
[4] Not swing-beds but general-hospital-based long-term care beds.

SOURCE: Health Care Financing Administration: *Analysis of State Medicaid Program Characteristics, 1984.* HCFA Pub. No. 03204. Office of the Actuary. Washington. U.S. Government Printing Office, Aug. 1985.

Table 4.25

Medicaid Supplemental Security Income eligibility determination and status of Medicaid Management Information System, by jurisdiction: March 1984

Medicaid jurisdiction	Supplemental Security Income eligibility determination[1]			Medicaid Management Information System			
	Section 1634	State determination	209(b) State	Certified	Certification anticipated fiscal year 1985	Certification implementation plan	None
Alabama	X			X			
Alaska		X					X
Arkansas	X			X			
California	X			X			
Colorado	X			X			
Connecticut			X	X			
Delaware	X						X
District of Columbia	X			X			
Florida	X			X			
Georgia	X			X			
Hawaii			X	X			
Idaho		X		X			
Illinois			X	X			
Indiana			X	X			
Iowa	X			X			
Kansas		X		X			
Kentucky[2]	X				X		
Louisiana	X			X			
Maine	X			X			
Maryland	X					X	
Massachusetts	X					X	
Michigan	X			X			
Minnesota			X	X			
Mississippi		X		X			
Missouri			X	X			
Montana	X			X			
Nebraska			X	X			
Nevada		X					X
New Hampshire			X	X			
New Jersey	X			X			
New Mexico	X			X			
New York	X			X			
North Carolina			X	X			
North Dakota			X	X			
Ohio			X	X			
Oklahoma			X	X			
Oregon		X		X			
Pennsylvania	X			X			
Rhode Island	X						X
South Carolina	X			X			
South Dakota	X			X			
Tennessee	X					X	
Texas	X			X			
Utah			X	X			
Vermont	X			X			
Virginia			X	X			
Washington	X			X			
West Virginia	X			X			
Wisconsin	X			X			
Wyoming	X						X

[1] Eligibility determination for the territories is based on separate regulations and is found in 42 *Code of Federal Regulations* 436.
[2] Kentucky Medicaid Management Information System has now been certified retroactive to December 1983.

SOURCES: Health Care Financing Administration, Bureau of Eligibility, Reimbursement, and Coverage: Data from the Division of Medicaid Eligibility Policy and Bureau of Program Operations: Data from the Division of Medicaid Procedures.

Table 4.26

Arizona health care program costs and retrospective estimate of traditional Medicaid costs, by basis of eligibility: Fiscal years 1983–84

Program and estimated costs	Basis of eligibility									
	Total		Aged		Blind		Disabled		AFDC[1]	
	1983	1984	1983	1984	1983	1984	1983	1984	1983	1984
	Amount in thousands									
Program costs incurred	$79,114.4	$87,828.6	$6,203.2	$7,456.0	$835.3	$967.9	$29,326.8	$35,089.0	$42,749.1	$44,315.8
Capitation payments	67,616.2	76,832.8	4,805.1	5,948.1	636.5	890.3	24,795.9	30,523.2	37,378.8	39,471.2
Fee-for-service claims	6,950.4	6,602.5	274.5	241.3	67.5	15.5	2,112.6	2,003.4	4,495.9	4,342.3
Part B premium	1,902.2	2,274.1	1,049.4	1,254.6	21.4	25.5	831.4	994.0	0	0
Retrospective estimate of traditional program costs	77,345.5	91,013.5	6,338.3	8,112.6	826.4	929.0	29,823.2	35,832.6	40,357.6	46,139.4
Total savings or loss	– 1,769.0	3,184.8	135.1	656.6	– 8.9	– 38.9	496.4	743.5	– 2,391.5	1,823.6
	Amount									
Average recipient cost per month[2]	[3]$78.96	$83.22	$68.16	$76.05	$147.25	$147.25	$155.69	$167.11	$58.54	$60.22
	Months									
Person months of Federal eligibility	979,561	1,093,588	92,992	106,674	5,612	6,309	191,555	214,425	689,402	766,180
	Percent									
Savings as percent of retrospective estimate	– 2.29	3.50	2.13	8.09	– 1.08	– 4.18	1.66	2.08	– 5.93	3.95

[1] Aid to Families with Dependent Children.
[2] Estimated average incurred cost per capita for comparable beneficiaries in comparable States.
[3] Represents a weighted average.

SOURCE: Trapnell, G., McKusick, D., Wrightson, C. W., et al.: *Evaluation of the Arizona Health Care Cost Containment System: Comparison of AHCCCS Program Cost with that of a Traditional Medicaid Program.* Contract No. HCFA–500–83–0027. Prepared for Health Care Financing Administration. Menlo Park, Calif. SRI International, Apr. 1986.

extending coverage to a number of other groups meeting AFDC income and resource requirements, the largest of which were first-time pregnant women who would be eligible for AFDC if a child were born; two-parent families in which the principal breadwinner was unemployed; pregnant women in two-parent families; and children under age 18 or 21 in either two-parent families (Ribicoff children) or various nonparental custodial arrangements. DEFRA drops this option and requires States to provide categorically needy coverage to the following groups provided they meet AFDC income and resource requirements:

- First-time pregnant women who would be eligible for AFDC (or would be eligible as AFDC unemployed parents if the State covered this group) if the child were born. Medical verification of pregnancy is required.
- Pregnant women in two-parent families in which the principal breadwinner is unemployed. Medical verification of pregnancy is required.
- All children born on or after October 1, 1983, up to age 5, including those in two-parent families.

This section became effective October 1, 1984. Where State legislation is necessary, the State is not considered out of compliance until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature held after the date of enactment.

Clarification of Medicaid entitlement for certain newborns (section 2362)

Under prior law, Medicaid application procedures in some States failed to provide for automatic addition of a newborn child to a Medicaid beneficiary's family unit for coverage purposes. Section 2362 makes application procedures consistent throughout the States by requiring them to deem eligible for Medicaid a child born to a woman eligible for and receiving Medicaid at the time of the child's birth. In addition, the child must be deemed eligible for 1 year, as long as the mother remains eligible for Medicaid and the child remains a member of her household. Section 2362 applies only to children born on or after October 1, 1984.

Recertification of SNF and ICF patients (section 2363)

Under prior law, States were required to show evidence of a satisfactory recertification program in their Medicaid plan. The recertification had to include evidence that a physician (or a physicians' assistant or nurse practitioner under the supervision of a physician) recertified the need for continuing skilled nursing facility and intermediate care facility services every 60 days. The law also required 100-percent compliance with the recertification requirements. The Federal penalty imposed on States that failed to have an adequate utilization control program was 33 1/3 percent times the ratio of the number of patients in facilities with one or more records out of compliance to the total number of patients in facilities in the State.

Section 2363 provides for recertification requirements for both SNF and ICF patients to become State Medicaid plan requirements. Recertification of SNF patients is required 30, 60, and 90 days after admission and thereafter every 60 days. Recertification of ICF patients is required 60–180 days after initial certification; 12, 18, and 24 months after initial certification; and annually thereafter.

This provision also permits a 10-day grace period if the State can demonstrate that the physician had good cause for missing the recertification deadline. Beginning July 1, 1984, the Federal penalty imposed under prior law no longer applies to the recertification requirements for SNF and ICF patients. However, the penalty continues to apply to the requirement that States have an effective medical review program. Section 2363 became effective with calendar quarters beginning on or after enactment of the legislation, except for admissions that occurred before the date of enactment, which are not required to be recertified more frequently than under prior law.

Waiver of certain HMO membership requirements (section 2364)

Under prior law, the proportion of Medicare and Medicaid beneficiaries enrolled in an HMO or other prepaid health plan delivering Medicaid services on a risk basis could not exceed 75 percent of total enrollment. In the case of public HMO's, however, this requirement may now be waived if it is determined that special circumstances warrant the waiver and the plan is making reasonable efforts to enroll members other than Medicare and Medicaid beneficiaries. Moreover, Medicaid eligibles are permitted to disenroll without cause with a 1-month notice.

Section 2364 expands waivers of enrollment requirements to include certain nonprofit HMO's. The nonprofit HMO must have at least 25,000 enrollees. It must also have been federally qualified for at least 4 years and continue to be qualified. Moreover, the HMO must provide basic health services through its staff, be located in a medically underserved area, and have previously received a waiver of the enrollment limitation under section 1115 of the Social Security Act. The Secretary of DHHS must still determine that special circumstances warrant the waiver and that the organizations have made and are making reasonable efforts to enroll members other than Medicare and Medicaid beneficiaries.

Under section 2364, States may require Medicaid beneficiaries who choose to enroll in HMO's to remain in the HMO for up to 6 months unless they have good cause to disenroll before that time. States must establish effective procedures for reviewing requests for disenrollment on a prompt and fair basis. This restriction can be imposed only if the providers are either federally qualified HMO's or prepaid health plans that are receiving and have received (at least 2 years prior to contracting with Medicaid) grants of at least $100,000 under the Migrant Health Center, Community Health Center, or Appalachian Regional Commission

programs. Section 2364 took effect upon enactment of the legislation.

Flexibility in setting payment rates for hospitals furnishing long-term care services (section 2369)

Under prior law, specific rules were established for determining payment rates for small rural hospitals furnishing skilled nursing or intermediate care facility services under Medicaid. Section 2369 permits States the alternative of paying for long-term care services at these hospitals either on the basis of the rates provided under current law or on the basis of the same general criteria that are applicable to rates for similar services provided by other hospitals and nursing homes. Whatever payment method a State chooses must be applied to all the hospitals in question. Section 2369 became effective upon enactment of the legislation.

Medicaid clinic administration (section 2371)

Under prior law, clinic services were an optional service in the Medicaid program. In some cases, regulations had been interpreted as requiring that clinic administrators be physicians. Section 2371 clarifies the regulations and allows States to cover clinic services furnished by or under the direction of a physician, whether or not the clinic itself is administered by a physician. Section 2371 became effective for services provided on or after the date of enactment.

Payments to territories (section 2365)

Under prior law, annual Federal Medicaid payments could not exceed $45 million for Puerto Rico, $1.5 million for the Virgin Islands, $1.4 million for Guam, $350,000 for the Northern Mariana Islands, and (beginning with fiscal year 1983) $750,000 for America Samoa. Effective fiscal year 1984, section 2365 raised the annual ceiling to $63.4 million for Puerto Rico, $2.1 million for the Virgin Islands, $2.0 million for Guam, $550,000 for the Northern Mariana Islands, and $1.15 million for American Samoa.

Payment for psychiatric hospital services (section 2366)

Under prior law, reimbursement for hospital inpatients who where awaiting nursing home placement was limited to the State's average daily rate for comparable services provided in a skilled nursing facility or intermediate care facility. Section 2366 allows for a phased-in reduction of the hospital rate to the lower nursing home rate for public psychiatric hospitals starting July 1, 1985, for the 12-month periods ending June 30, 1986, and June 30, 1987. The reductions are one-third (for the year ending June 30, 1986) and two-thirds (for the year ending June 30, 1987) of the amounts that would otherwise have been required. This provision took effect upon enactment of the legislation.

Payment schedule for certain back claims due States (section 2637)

The Continuing Appropriations for Fiscal Year 1983 Act (Public Law 97-276) provided that no payment be made for Medicaid and certain other program expenditures incurred before 1979 (including court-ordered retroactive payments) until a repayment schedule was established in the Social Security Act. Effective upon enactment of DEFRA, a payment schedule for court-ordered reimbursement was established, as follows: payment within 30 days of enactment for allowable claims identified in the U.S. District Court decision *State of Connecticut* v. *Heckler* and payment for other court-ordered claims for expenditures before fiscal year 1979 as soon as DHHS determines them to be allowable.

Mandatory assignment of payment rights by Medicaid recipients (section 2367)

Under prior law, States were permitted to require Medicaid applicants to assign to the State their rights to medical support and third-party payments for medical care. Section 2367 mandates States to require Medicaid applicants to assign to the State their right to third-party payments as a condition of eligibility. This section is effective October 1, 1984. Where State legislation is necessary, the State is not considered out of compliance until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature held after the date of enactment.

Requirements for medical review and independent professional review (section 2368)

Under prior law, Medicaid medical review requirements for SNF's and independent professional review requirements for ICF's were similar. Both called for teams of physicians, registered nurses, and other appropriate personnel to conduct similar kinds of review. Effective upon enactment of the legislation, section 2368 makes State plan requirements for medical review and independent professional review consistent for both ICF's and SNF's.

Authority of the Secretary to issue and enforce subpoenas under Medicaid (section 2370)

Under prior law, the Secretary of DHHS was given the authority to issue and seek enforcement of subpoenas under Medicare to obtain information needed in connection with hearings, investigations, and other

matters related to program fraud and abuse. Section 2370 extended the Secretary's authority to issue and seek enforcement of subpoenas under Medicaid to the same extent as is allowed under Medicare.

Miscellaneous technical amendments (section 2373)

Section 137(a)(8) of TEFRA required States to use the same methodology for evaluating the income and resources of medically needy applicants as was used in the relevant cash assistance program. Section 2373 of DEFRA required the Secretary of DHHS to submit to Congress, within 12 months of the enactment of legislation, a report and recommendations on the appropriateness of the requirements used for the cash assistance programs in cases of Medicaid applicants who do not receive cash benefits. Also, from enactment until 18 months after the report was submitted to Congress, the Secretary was prohibited from imposing any sanctions on States for using requirements in medically needy cases that were less restrictive than those used in the cash assistance programs.

Other changes affecting Medicaid

Other changes affecting the Medicaid program were made to the eligibility provisions for Aid to Families with Dependent Children and Supplemental Security Income and to income eligibility verification procedures.

Under prior law, States were required to provide Medicaid to all AFDC recipients and most or all SSI recipients. A number of changes made to both programs directly affect Medicaid caseloads and program costs. Two changes, effective October 1, 1984, have the largest impact on the Medicaid program by increasing the number of eligibles. First, a work transition provision requires States to extend Medicaid coverage of working families who lose AFDC when their entire earnings start to be counted. Coverage must be extended for an additional 9 months and, at State option, may be continued for 6 months beyond the mandatory extension. Second, States are required to include the entire family, consisting of the parents and all minor siblings, and to count all family incomes when determining the family's eligibility for AFDC. Family members may not apply for AFDC as separate individuals.

Under prior law, information from the Internal Revenue Service and State unemployment compensation programs was not available on the same terms to all States and Federal agencies administering means-tested welfare and health programs. Effective April 1, 1985 (except as otherwise specified), States must have in effect an income and eligibility verification system for use in administering the Medicaid, unemployment compensation, and food stamp programs. In addition, the Internal Revenue Service must now disclose information on recipients' unearned income at State request. State programs must use standardized information formats, provide safeguards for confidentiality, and include measures to protect applicants or recipients from the consequences of erroneous information.

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Appendix A
Medicare carriers and intermediaries

Blue Cross Association

Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

Blue Cross plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Alaska—See Blue Cross of Washington and Alaska

Blue Cross and Blue Shield of Arizona, Inc.
2444 W. Las Palmaritas Drive
Phoenix, Arizona 85021
Mailing address:
P.O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91470
Mailing address:
P.O. Box 70000
Van Nuys, California 91470

Rocky Mountain Hospital and Medical Service
(d.b.a. Blue Cross and Blue Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross and Blue Shield of Delaware, Inc.
One Brandywine Gateway
P.O. Box 1991
Wilmington, Delaware 19899

Group Hospitalization and Medical Services, Inc.
(d.b.a. Blue Cross and Blue Shield of the National Capitol Area)
550 Twelfth Street, SW.
Washington, D.C. 20024

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32201

Blue Cross and Blue Shield of Georgia, Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho Health Service, Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707

Health Care Service Corp.
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross of Western Iowa and South Dakota
Hamilton Blvd. and I-29
Sioux City, Iowa 51102

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service and Indemnity Company
(d.b.a. Blue Cross of Louisiana)
5527 Reitz Avenue
Baton Rouge, Louisiana 70820-7006

Associated Hospital Service of Maine
(d.b.a. Maine Blue Cross and Blue Shield)
110 Free Street
Portland, Maine 04101

Blue Cross and Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of Massachusetts
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
P.O. Box 64357
St. Paul, Minnesota 55164

Blue Cross and Blue Shield of Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39216

Blue Cross Hospital Service, Inc., of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 10th Avenue, South
P.O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Main Post Office Station
Omaha, Nebraska 68180

NOTE: d.b.a. means "doing business as."

New Hampshire-Vermont Health Service
Two Pillsbury Street
Concord, New Hampshire 03301

Hospital Service Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross and Blue Shield, Inc.
12800 Indian School Road, NE.
Albuquerque, New Mexico 87112

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Blue Cross of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Community Mutual Insurance Company
1351 William Howard Taft Road
P.O. Box 14189
Cincinnati, Ohio 45214

Group Health Service of Oklahoma, Inc.
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Blue Cross and Blue Shield of Oregon
100 S.W. Market Street
P.O. Box 1271
Portland, Oregon 97201

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western Pennsylvania
One Smithfield Street
Pittsburgh, Pennsylvania 15222

Blue Cross and Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota—See Blue Cross of Western Iowa and South Dakota

Blue Cross and Blue Shield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402

Blue Cross and Blue Shield of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270
Salt Lake City, Utah 84130

Blue Cross and Blue Shield of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23279

Blue Cross of Washington and Alaska
7001-220th, SW.
P.O. Box 327
Mountlake Terrace, Washington 98043

Blue Cross and Blue Shield of West Virginia, Inc.
P.O. Box 231
Charleston, West Virginia 25325

Blue Cross and Blue Shield United of Wisconsin
401 West Michigan Street
P.O. Box 2025
Milwaukee, Wisconsin 53201

Blue Cross and Blue Shield of Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

Blue Shield plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians Service
(d.b.a. Blue Shield of California)
No. 2 Northpoint
P.O. Box 7013
San Francisco, California 94120

Rocky Mountain Hospital and Medical Service
(d.b.a. Blue Cross and Blue Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Delaware—See Pennsylvania Blue Shield

District of Columbia—See Pennsylvania Blue Shield

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 1798
Jacksonville, Florida 32201

Health Care Service Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Associated Insurance Companies, Inc.
(d.b.a. Blue Cross and Blue Shield of Indiana)
Medicare Department
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
1218 Harrodsburg Road
Lexington, Kentucky 40504

Louisiana—See Arkansas Blue Cross and Blue Shield, Inc.

Maine—See Blue Shield of Massachusetts, Inc.

Blue Cross and Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02110

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
P.O. Box 64357
St. Paul, Minnesota 55164

Blue Cross and Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
P.O. Box 4310
404 Fuller Avenue
Helena, Montana 59601

Nebraska—See Blue Shield of Iowa

Blue Shield of Western New York
298 Maine Street
Buffalo, New York 14202

Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud de Puerto Rico, Inc.
GPO Box 3628
San Juan, Puerto Rico 00936

Blue Cross and Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota—See Blue Shield of North Dakota

Blue Cross and Blue Shield of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270, Medicare B
Salt Lake City, Utah 84130

Washington Physicians Service
4th & Battery Building
6th Floor
2401 4th Avenue
Seattle, Washington 98121

Wisconsin Physicians' Service Insurance Corporation
1717 West Broadway
Madison, Wisconsin 53713

Commercial, independent, State, and other

Aetna Life and Casualty Company
151 Farmington Avenue
Hartford, Connecticut 06156

Cooperativa de Seguros de Vida de Puerto Rico
GPO Box 3428
San Juan, Puerto Rico 00936

The Equitable Life Assurance Society of the United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance Company
13045 Tesson Ferry Road
St. Louis County, Missouri 63128

Group Health, Incorporated
330 West 42nd Street
New York, New York 10036

Hawaii Medical Service Association
818 Keeaumoku
P.O. Box 860
Honolulu, Hawaii 96808

Mutual of Omaha Insurance Company
P.O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
P.O. Box 57
Columbus, Ohio 43216

The Prudential Insurance Company of America
Tri-City Office, Drawer 471
Millville, New Jersey 08332

Transamerica Occidental Life Insurance Company
12th at Hill Street
P.O. Box 54905
Los Angeles, California 90054

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06183

Railroad Retirement Board
844 Rush Street
Chicago, Illinois 60611

Appendix B

Medicaid agencies and fiscal agents

Single State agencies and State medical assistance units

Alabama (Region IV):
Single State agency and medical assistance unit:
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277-2710

Alaska (Region X):
Single State agency:
Alaska Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811
907 465-3030

Medical assistance unit:
Division of Medical Assistance
Alaska Department of Health and Social Services
Pouch H-07
Juneau, Alaska 99811
907 465-3355

Arizona (Region IX):
Single State agency and medical assistance unit:
Arizona Health Care Cost Containment System Administration
801 East Jefferson Street
Phoenix, Arizona 85034
602 234-3655

Arkansas (Region VI):
Single State agency:
Arkansas Department of Human Services
Seventh and Main Streets
Donaghey Building, 3rd Floor
Little Rock, Arkansas 72201
501 371-1001

Medical assistance unit:
Office of Medical Services
Division of Economic and Medical Services
Arkansas Department of Human Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1806

California (Region IX):
Single State agency:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 445-1248

Medical assistance unit:
California State Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 322-5824

Colorado (Region VII):
Single State agency:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218-0899
303 294-5800

Medical assistance unit:
Colorado Department of Social Services
P.O. Box 181000
Denver, Colorado 80218-0899
303 294-5901

Connecticut (Region I):
Single State agency:
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2008

Medical assistance unit:
Medical Care Administration
Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2934

Delaware (Region III):
Single State agency:
Delaware Department of Health and Social Services
Administration Building
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6705

Medical assistance unit:
Medical Assistance Services
Delaware Department of Health and Social Services
Biggs Building
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6139

District of Columbia (Region III):
Single State agency:
Department of Human Services
801 North Capital Street
Room 700
Washington, D.C. 20002
202 727-0310

Medical assistance unit:
Office of Health Care Financing/Office of the Controller
D.C. Department of Human Services
1331 H Street, NW.
Room 500
Washington, D.C. 20005
202 727-0735

Florida (Region IV):
Single State agency:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
904 488-7721

Medical assistance unit:
Florida Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Building 6, Room 233
Tallahassee, Florida 32301
904 488-3560

Georgia (Region IV):
Single State agency and medical assistance unit:
Georgia Department of Medical Assistance
Twin Towers Office Building
Room 1220-C, West Tower
2 Martin Luther King Drive
Atlanta, Georgia 30334
404 656-4479

Guam (Region IX):
Single State agency and medical assistance unit:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910
671 734-2903

Hawaii (Region IX):
Single State agency:
Hawaii Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6260

Medical assistance unit:
Health Care Administration Division
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-3855

Idaho (Region X):
Single State agency:
Idaho Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4079

Medical assistance unit:
Bureau of Medical Assistance
Idaho Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4326

Illinois (Region V):
Single State agency:
Illinois Department of Public Aid
316 South Second Street
Springfield, Illinois 62762
217 782-6716

Medical assistance unit:
Illinois Department of Public Aid
628 East Adams Street, 3rd Floor
Springfield, Illinois 62763
217 782-2550

Indiana (Region V):
Single State agency:
Indiana Department of Public Welfare
State Office Building
100 North Senate Avenue, Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical assistance unit:
Indiana Department of Public Welfare
State Office Building
100 North Senate Avenue, Room 701
Indianapolis, Indiana 46204
317 232-4324

Iowa (Region VII):
Single State agency:
Iowa Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319
515 281-5452

Medical assistance unit:
Bureau of Medical Services
Iowa Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319
515 281-8621

Kansas (Region VII):
Single State agency:
Kansas Department of Social and Rehabilitation Services
State Office Building, 6th Floor
Topeka, Kansas 66612
913 296-3271

Medical assistance unit:
Kansas Department of Social and Rehabilitation Services
State Office Building, 6th Floor
Room 628-S
Topeka, Kansas 66612
913 296-3981

Kentucky (Region IV):
Single State agency:
Kentucky Department for Medicaid Services
CHR Building, Third Floor
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Medical assistance unit:
Kentucky Department for Medicaid Services
CHR Building, Third Floor
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Louisiana (Region VI):
Single State agency:
Louisiana Department of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical assistance unit:
Medical Assistance Programs
Louisiana Department of Health and Human Resources
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3956

Maine (Region I):
Single State agency:
Maine Department of Human Services
221 State Street
Statehouse, Station II
Augusta, Maine 04333
207 289-2736

Medical assistance unit:
Bureau of Medical Services
Whitten Road
Statehouse, Station II
Augusta, Maine 04333
207 289-2674

Maryland (Region III):
Single State agency:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street
Baltimore, Maryland 21201
301 225-6500

Medical assistance unit:
Maryland Department of Health and Mental Hygiene
Herbert R. O'Connor Building
201 West Preston Street, Room 524
Baltimore, Maryland 21201
301 225-6535

Massachusetts (Region I):
Single State agency:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0200

Massachusetts Commission for the Blind:
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Medical assistance unit:
Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Massachusetts 02111
617 574-0205

Medical assistance:
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Michigan (Region V):
Single State agency:
Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical assistance unit:
Michigan Department of Social Services
921 West Holmes
P.O. Box 30037
Lansing, Michigan 48909
517 334-7262

Minnesota (Region V):
Single State agency:
Minnesota Department of Human Services
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical assistance unit:
Bureau of Income Maintenance
Minnesota Department of Public Welfare
Space Center Building, 1st Floor
444 Lafayette Road
Saint Paul, Minnesota 55101
612 296-2766

Mississippi (Region IV):
Single State agency and medical assistance unit:
Division of Medicaid
Office of the Governor
4785 1-55 North
P.O. Box 16786
Jackson, Mississippi 39236-0786
601 981-4507

Missouri (Region VII):
Single State agency:
Missouri Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65102
314 751-4815

Medical assistance unit:
Division of Medical Services
Missouri Department of Social Services
308 East High Street
Jefferson City, Missouri 65103
314 751-6922

Montana (Region VII):
Single State agency:
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-5622

Medical assistance unit:
Economic Assistance Division
Montana Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-4540

Nebraska (Region VII):
Single State agency:
Nebraska Department of Social Services
301 Centennial Mall South, 5th Floor
Lincoln, Nebraska 68509
402 471-3121

Medical assistance unit:
Nebraska Department of Social Services
301 Centennial Mall South, 5th Floor
Lincoln, Nebraska 68509
402 471-9330

Nevada (Region IX):
Single State agency:
Nevada Department of Human Resources
Kinkead Building—Capitol Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical assistance unit:
Nevada Medical Welfare Division
Nevada Department of Human Resources
2527 North Carson Street
Carson City, Nevada 89710
702 885-4698

New Hampshire (Region I):
Single State agency:
New Hampshire Department of Health and Human Services
State Office Park East
6 Hazen Drive
Concord, New Hampshire 03301-6505
603 271-4321

Medical assistance unit:
Office of Medical Services
New Hampshire Division of Health and Human Services
Health and Welfare Building
Hazen Drive
Concord, New Hampshire 03301-6521
603 271-4353

New Jersey (Region II):
Single State agency:
New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, New Jersey 08625
609 292-3717

Medical assistance unit:
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
Building No. 7
Quakerbridge Plaza, CN 712
Trenton, New Jersey 08625
609 588-2600

New Mexico (Region VI):
Single State agency:
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-4072

Medical assistance unit:
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-4315

New York (Region II):
Single State agency:
New York State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical assistance unit:
Division of Medical Assistance
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (Region IV):
Single State agency:
North Carolina Department of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical assistance unit:
Division of Medical Assistance
North Carolina Department of Human Resources
1985 Umstead Drive
Raleigh, North Carolina 27603
919 733-2060

North Dakota (Region VIII):
Single State agency:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Medical assistance unit:
North Dakota Department of Human Services
State Capitol Building
Bismarck, North Dakota
701 224-2321

Ohio (Region V):
Single State agency:
Ohio Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215
614 466-6282

Medical assistance unit:
Ohio Department of Human Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215
614 466-3196

Oklahoma (Region VI):
Single State agency:
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical assistance unit:
Medical Services Division
Oklahoma Department of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 557-2504

Oregon (Region X):
Single State agency:
Oregon Department of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 378-3034

Medical assistance unit:
Adult and Family Services Division
Oregon Department of Human Resources
203 Public Service Building
Salem, Oregon 97310
503 378-2263

Pennsylvania (Region III):
Single State agency:
Pennsylvania State Department of Public Welfare
Health and Welfare Building, Room 333
Harrisburg, Pennsylvania 17120
717 787-2600

Medical assistance unit:
Pennsylvania State Department of Public Welfare
Health and Welfare Building, Room 515
Harrisburg, Pennsylvania 17120
717 787-1870

Puerto Rico (Region II):
Single State agency:
Puerto Rico Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809 751-8259

Medical assistance unit:
Office of Economic Aid to the Medically Indigent
Medical Assistance Program
Department of Health
Building A
Call Box 70184
San Juan, Puerto Rico 00936
809 765-9941

Rhode Island (Region I):
Single State agency:
Rhode Island Department of Human Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical assistance unit:
Rhode Island Department of Human Services
The Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-3575

South Carolina (Region IV):
Single State agency:
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 758-3175

Medical assistance unit:
Bureau of Health Services
South Carolina State Health and Human Services Finance Commission
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 758-8182

South Dakota (Region VIII):
Single State agency:
South Dakota Department of Social Services
Kneip Building
700 North Illinois
Pierre, South Dakota 57501
605 773-3165

Medical assistance unit:
Office of Medical Services
South Dakota Department of Social Services
Kneip Building
700 North Illinois
Pierre, South Dakota 57501
605 773-3495

Tennessee (Region IV):
Single State agency:
Tennessee Department of Health and Environment
344 Cordell Hull Building
Nashville, Tennessee 37219
615 741-3111

Medical assistance unit:
Bureau of Medicaid
Tennessee Department of Health and Environment
729 Church Street
Nashville, Tennessee 37219
615 741-0213

Texas (Region VI):
Single State agency:
Texas Department of Human Services
P.O. Box 2960
Austin, Texas 78769
512 450-3030

Medical assistance unit:
Texas Department of Human Services
P.O. Box 2960
Mail Code 600W
Austin, Texas 78769
512 450-3050

Utah (Region VIII):
Single State agency:
Utah Department of Health
P.O. Box 45500
Salt Lake City, Utah 84145-0500
801 533-6111

Medical assistance unit:
Division of Health Care Financing
Utah Department of Health
P.O. Box 45500
Salt Lake City, Utah 84145-0500
801 533-6151

Vermont (Region I):
Single State agency:
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2220

Medical assistance unit:
Division of Medical Services
Vermont Department of Social Welfare
Agency of Human Services
103 South Main Street
Waterbury, Vermont 05676
802 241-2880

Virgin Islands (Region II):
Single State agency:
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-0117

Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Virgin Islands Department of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-4624

Virginia (Region III):
Single State agency and medical assistance unit:
Virginia Department of Medical Assistance Services
109 Governor Street, Suite 800
Richmond, Virginia 23219
804 786-7933

Washington (Region X):
Single State agency and medical assistance unit:
Division of Medical Assistance
Washington Department of Social and Health Services
Mail Stop HB-41
Olympia, Washington 98504
206 753-1777

West Virginia (Region III):
Single State agency and medical assistance unit:
West Virginia Department of Human Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-8990

Wisconsin (Region V):
Single State agency:
Wisconsin Department of Health and Social Services
1 West Wilson Street, Room 663
P.O. Box 7850
Madison, Wisconsin 53707
608 266-3681

Medical assistance unit:
Bureau of Health Care Financing
Wisconsin Department of Health and Social Services
1 West Wilson Street
Room 244
P.O. Box 309
Madison, Wisconsin 53701
608 266-2522

Wyoming (Region VIII):

Single State agency:
Wyoming Department of Health and Social Services
317 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7657

Medical assistance unit:
Medical Assistance Services
Division of Health and Social Services
Hathaway Building, Room 450
Cheyenne, Wyoming 82002
307 777-7531

Medicaid fiscal agents and health insuring agencies

Jurisdiction	Fiscal agent(s) or health insuring agency	Type of claims handled
Alabama	Alacaid	Institutional, noninstitutional, drugs.
Alaska	Computer Sciences Corp.	Hospital—inpatient and outpatient, physician, pharmacy, dental, nursing facility, EPSDT, other medical providers.
American Samoa	No fiscal agent	
Arizona	No fiscal agent	
Arkansas	Electronic Data Systems	All services provided in Arkansas State plan, including crossover claims.
California	Computer Science Corp.	All claim types (except dental) in the State except for three northern counties (Lake, Sonoma, Mendocino).
	Delta Dental	Dental claims only. Capitation-based system. California Dental Services receives monthly capitation payments from the State and pays fee-for-service claims received from participating dentists. The cost/claim rate represents administrative costs of the contract over 5 years.
Colorado	Computer Science Corp.	All services provided in Colorado State plan, including crossover claims.
Connecticut	Electronic Data Systems Federal	All services provided in the Connecticut State plan, including crossover claims.
Delaware	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, and long-term care. Crossover claims—home health, laboratory, and X-ray.
District of Columbia	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, and long-term care.
Florida	Electronic Data Systems Federal	All services provided in Florida State plan.
Georgia	Electronic Data Systems Federal	All services provided in Georgia State plan.
	The Computer Company	All services provided in Georgia State plan.
Guam	No fiscal agent	
Hawaii	Hawaii Medical Service Association	Processing from receipt to payment. All claim types—hospital, inpatient, nursing home care, intermediate care facility, physicians' services, other practitioners, dental services, hospital outpatient, laboratory, X-ray, home health, drugs, other care, family planning, and screening services.
Idaho	Electronic Data Systems Federal	Hospital—inpatient and outpatient, physician, dental, pharmacy, EPSDT, nursing home, other medical providers.

NOTE: EPSDT means early and periodic screening, diagnosis, and treatment.

Illinois	No fiscal agent	
Indiana	Blue Cross and Blue Shield of Indiana (insuring arrangement)	All services provided in Indiana State plan, including crossover claims.
Iowa	United Information Systems	All services provided in Iowa State plan except intermediate care facilities.
Kansas	Electronic Data Systems Federal	All services provided in Kansas State plan, including skilled nursing facility crossover claims.
Kentucky	Electronic Data Systems	All services provided in Kentucky State plan.
Louisiana	Systems Development Corporation	All services provided in Louisiana State plan, including crossover claims.
Maine	No fiscal agent	
Maryland	No fiscal agent	
Massachusetts	Systems Development Corporation	All services provided in Massachusetts State plan, including crossover claims.
Michigan	No fiscal agent	
Minnesota	No fiscal agent	
Mississippi	Electronic Data Systems Federal	All services provided in Mississippi State plan.
Missouri	General American Consultec	All services provided in Missouri State plan.
Montana	General American Consultec	All services provided in Montana State plan.
Nebraska	No fiscal agent	
Nevada	Blue Cross/Blue Shield of Nevada	Inpatient hospital services, mental hospital services for aged, all intermediate care facility services, skilled nursing facility services, physicians' services, dental services, other practitioners' services, outpatient hospital services, clinic services, home health services, family planning services, laboratory and X-ray services, prescribed drugs, EPSDT, rural health clinic services, sterilization services, other care, Part A and B crossover claims.
New Hampshire	Electronic Data Systems Federal	All services provided in New Hampshire State plan, including crossover claims.
New Jersey	Prudential	All ambulatory care services and non-hospital-based home health. Some inpatient and outpatient services.
	New Jersey Blue Cross*	Inpatient and outpatient hospital and drugs, maintenance of eligibility file.
New Mexico	Electronic Data Systems	All services provided in New Mexico State plan, including crossover claims.

New York	McAuto Systems Group Inc. (McDonnell Douglas)	All services provided in New York State plan except health-related facilities administered by New York City Bureau of Medical Assistance.
North Carolina	Electronic Data Systems Federal	All services provided in North Carolina State plan.
North Dakota	No fiscal agent	
Ohio	No fiscal agent	
Oklahoma	Systems Development Corporation	All services provided in Oklahoma State plan, including crossover claims.
Oregon	No fiscal agent	
Pennsylvania	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, and long-term care. (Front-end claims processing, data entry, and microfilming activities only.)
Rhode Island	No fiscal agent	
South Carolina	No fiscal agent	
South Dakota	No fiscal agent	
Tennessee	The Computer Company	All claims provided in Tennessee State plan.
Texas	National Heritage Co. (insuring arrangement)	All services provided in Texas State plan except nursing home, EPSDT, dental, prescribed drugs, adult day health, personal care in recipient's home, and transportation (other than ambulance).
Utah	Utah Blue Cross/Blue Shield	All services provided in Utah State plan, including crossover claims.
Vermont	Electronic Data Systems	All services provided in Vermont State plan, including crossover claims.
Virginia	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, and long-term care.
Washington	Consultec, Inc.	Hospital—inpatient and outpatient, physician, dental, pharmacy, nursing home, EPSDT, other medical providers.
West Virginia	The Computer Company	Dental, drugs, inpatient, outpatient, EPSDT, physician, and long-term care.
Wisconsin	Electronic Data Systems Federal	All services provided in Wisconsin State plan, including crossover claims.
Wyoming	Wyoming Dental Services	Dental (EPSDT only).

Appendix C
Where to call for information

Medicare

Assignment of Medicare claims
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Beneficiary assistance on claims and entitlement
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-9545

Beneficiary information
Office of Beneficiary Services (Baltimore) (301) 594-8131
Office of Beneficiary Services (D.C.) (202) 245-7684

Benefit appeal procedures
Office of Financial Operations
Bureau of Program Operations (301) 594-8431

Benefit information
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9690

Conditions of provider participation
Office of Standards and Certification
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9690

Contractor performance
Division of Performance Analysis
Bureau of Quality Control (301) 594-8000

Contracts
Division of Contracts
Office of Program Administration
Bureau of Program Operations (301) 594-9700

Cost estimates
Division of Medicare Cost Estimates
Office of the Actuary (301) 594-2826

Deductibles: Explanation of beneficiary liability
Bureau of Program Policy (301) 594-9324

Enrollment policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Entitlement
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Medicare and Medicaid fraud, abuse and waste
Health and Human Services (800) 638-3986 (MD toll free)
Office of the Inspector General (800) 368-5779 (nationwide toll free)

Medicare legislation
Medicare Branch
Office of Legislation and Policy (202) 245-2413

Peer review organizations
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Physician provider data
Analytical Studies Branch
Office of Research and Demonstrations (301) 597-1460

Prevailing charges directory
Office of Program Administration
Bureau of Program Operations (301) 594-9470

Problems: Beneficiaries
Office of Beneficiary Services (Baltimore) (301) 594-8131
Office of Beneficiary Services (D.C.) (202) 245-7684

Problems: General
Office of the Administrator
Office of Public Affairs (202) 245-6161

Procurements—Medicare
Division of Procurement
Office of Program Administration
Bureau of Program Operations (301) 594-8003

Public information
Office of Public Affairs (D.C.) (202) 245-0923
Office of Public Affairs (Baltimore) (301) 597-3883

Publications: Health Care Financing Administration
Office of Public Affairs (301) 597-2618

Publications: Office of Research and Demonstrations
Publications Office
Office of Research and Demonstrations (301) 597-2422

Quality care issues
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Quality control
Office of Quality Control Programs
Bureau of Quality Control (301) 597-1354

Reasonable charges
Bureau of Eligibility, Reimbursement, and Coverage (301) 597-1334

Regional offices, Health Care Financing Administration
Boston (617) 223-6871
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 221-2329
Chicago (312) 353-8057
Dallas (214) 767-6427
Kansas City (816) 374-5233
Denver (303) 837-2111
San Francisco (415) 556-0254
Seattle (206) 442-0425

Reimbursement methods
Division of Reimbursement and Economic Studies
Office of Research and Demonstrations (301) 594-8286

Reimbursement policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9760

Research and demonstration studies
Office of Research and Demonstrations (301) 597-3195

Rural health clinic services
Division of Operational Initiatives
Office of Program Administration
Bureau of Program Operations (301) 594-9101

Service coverage
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9690

State and contractor standards
Office of Financial Operations
Bureau of Program Operations (301) 594-8431

State buy-ins
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-9545

State certification cost data
Office of Standards and Certification
Health Standards and Quality Bureau (301) 597-5137

Statistics: Assignment rates
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Statistics: Beneficiaries
Division of Beneficiary Studies
Office of Research and Demonstrations (301) 597-1432

Statistics: Contractor workloads and cost
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Statistics: General
Division of Information Analysis
Bureau of Data Management and Strategy (301) 594-6705

Statistics: Institutional care
Institutional Studies Branch
Office of Research and Demonstrations (301) 597-5710

Statistics: Noninstitutional studies
Noninstitutional Studies Branch
Office of Research and Demonstrations (301) 597-1416

Statistics: Peer review organizations
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Medicaid

Abortion data
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Administration and training cost data
Office of Financial Management and Administrative Systems
Office of Management and Budget (301) 597-6672

Aid to Families with Dependent Children, energy assistance, need and payment standards
Office of Family Assistance
Office of Intergovernmental Communications (202) 245-2637

Beneficiary information
Office of Beneficiary Services (Baltimore) (301) 597-2272
Office of Beneficiary Services (D.C.) (202) 245-7684

Early and periodic screening, diagnosis, and treatment data
Child Health and Prevention Staff
Executive Office
Bureau of Program Operations (301) 597-0451

Eligibility
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Eligibility error rates
Eligibility Assessment Branch
Division of Program Benefits Assessment
Bureau of Quality Control (301) 597-1384

Expenditures
Total Program Expenditures
Division of State Agency Financial Management
Bureau of Program Operations (301) 597-1702

Federal financial participation
Division of State Agency Financial Management
Office of Financial Operations
Bureau of Program Operations (301) 597-1389

Freedom-of-choice waivers
Office of Eligibility Policy (301) 594-8692
Bureau of Eligibility, Reimbursement, and Coverage (301) 597-3870

Home and community-based waivers
Office of Coverage Policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9824

Medicaid fraud and abuse
Health and Human Services (800) 638-3986 (MD toll free)
Office of the Inspector General (800) 368-5779 (nationwide toll free)
Office of Investigations
State Fraud Branch (202) 472-3222

Medicaid institutional providers
Office of Statistics and Data Management
Bureau of Data Management and Strategy (301) 594-0942

Medicaid legislation
Medicaid Branch
Office of Legislation and Policy (202) 245-8220

Medicaid management information systems
Division of Medicaid Procedures
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-8440

Medicaid policy
Division of Policy Analysis
Office of Legislation and Policy (202) 472-5240

Medicaid vendor payments
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Medicare and Medicaid regulations: Regulations under development and status
Office of Regulations Management
Office of Executive Operations (301) 597-4462

Procurements—Medicaid
Division of Medicaid Procedures
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-8440

Public information
Office of Public Affairs (D.C.) (202) 245-6113
Office of Public Affairs (Baltimore) (301) 594-4323

Publications: Office of Research and Demonstrations
Publications Office
Office of Research and Demonstrations (301) 597-2422

Recipients
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Reference services
Division of Congressional Affairs and Reference Services
Office of Legislation and Policy (202) 426-3717

Regional offices, Health Care Financing Administration
Boston (617) 223-6871
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 221-2329
Chicago (312) 353-8057
Dallas (214) 767-6427
Kansas City (816) 374-5233
Denver (303) 837-2111
San Francisco (415) 556-0254
Seattle (206) 442-0425

Research
Program Studies Branch (301) 597-1428
Office of Research and Demonstrations (301) 597-1454

State and local administration and training
Office of Financial Management and Administrative Systems
Office of Management and Budget (301) 597-6672

State assessment
Division of Performance Analysis
Bureau of Quality Control (301) 594-8000

State certification cost data
Office of Standards and Certification
Health Standards Quality Bureau (301) 597-5137

State data
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Statistics: General
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Supplemental security income
Social Security Administration
Division of Program Management and Analysis
Office of Supplemental Security Income (202) 673-5747

Third-party liability
Division of Operational Initiatives
Office of Program Administration (301) 594-9101
Bureau of Program Operations (301) 594-6703

Utilization
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Appendix D
Glossary of Medicare and Medicaid terms

Aged—For purposes of enrollment under Medicare, persons 65 years of age or over are considered to be aged. Medicaid eligibility is determined on the basis of financial need for people who meet Supplemental Security Income eligibility criteria (aged, blind, or disabled individuals) and Aid to Families with Dependent Children criteria (adults and children). Eligibility determinations are made for an entire economic unit or "case" (sometimes a family) based on whether or not one member of a case meets the criteria. For example, an "aged" case could consist of a 66-year-old male and his 63-year-old wife. In contrast, a disabled enrollee could be over 65 years of age.

Arizona Health Care Cost Containment System (AHCCCS)—AHCCCS is a demonstration project designed as an innovative, competitive system for payment and delivery of health care services to the low-income population. The effects of AHCCCS on cost, quality, and utilization of health care are being evaluated by SRI International, Inc.

Assignment—An enrollee in the supplementary medical insurance program may agree with a provider of service to assign benefit rights to the provider. When this assignment method is used, the provider agrees to accept as the total charge for the covered service the amount that is approved by the carrier as the reasonable charge. The provider submits a claim to the carrier and is reimbursed for the reasonable charge, minus 20-percent coinsurance and any unmet deductible. The provider may then charge the enrollee only for the coinsurance and unmet deductible.

Automatic enrollment—Retirement and survivors insurance beneficiaries are automatically sent Medicare cards 3 months before they attain age 65; those entitled to disability benefits are automatically sent Medicare cards 3 months before the completion of 24 months of entitlement. These Medicare cards show entitlement to both hospital insurance and supplementary medical insurance (SMI). An enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Average compound rate of growth—Also called the average annual rate of change, this is a geometric rate of change in which a variable increases or decreases at the same rate each year. For example, an average annual rate of change of 10 percent, starting with a base of 100, would increase to 110 in the first year, 121 in the second year, and so on.

Benefit payments—These payments comprise all withdrawals from the Medicare hospital insurance and supplementary medical insurance trust funds for services rendered to Medicare enrollees. Payments include both reimbursements recorded on bills and payments made independently of the billing system (interim payments, end-of-year adjustments, and certain capitation payments).

Benefit period—A benefit period is the period used to limit Medicare benefits in the hospital insurance program. A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier—A carrier is an organization that has contracted with the Department of Health and Human Services to process claims and perform other services under Medicare's supplementary medical insurance program.

Categorically needy—Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who meet financial eligibility requirements for Aid to Families with Dependent Children, Supplemental Security Income, or an optional State supplement.

Coinsurance—Coinsurance is the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover. Under hospital insurance, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance (SMI), after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee. However, there is no coinsurance for home health services under SMI.

Copayment—Copayments are a type of cost sharing under Medicaid whereby insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered service—Covered services under the Medicare program are the services and supplies for which Medicare will reimburse. Examples of covered services are given in this glossary under specific headings, such as skilled nursing facility services. Covered services under the Medicaid program consist of a combination of mandatory and optional services within each State.

Customary charge—Customary charges are the amounts physicians or suppliers usually bill patients for furnishing particular services or supplies.

Deductible—Deductibles are the amounts paid by enrollees for covered services before Medicare makes reimbursements. The hospital insurance deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a 1-day inpatient hospital stay. The supplementary medical insurance deductible is, by law, the first $75 of covered charges per calendar year, effective January 1, 1982.

Diagnosis-related group—Diagnosis-related groups are classifications used for incorporating severity-of-illness measurements into the process of prospective payment determination for inpatient hospital services.

Disabled—For purposes of enrollment under Medicare, individuals under 65 years of age who have been entitled to disability benefits under the Social Security Act or the railroad retirement system for at least 24 months are considered disabled and are entitled to Medicare.

Discharge—A discharge is a formal release from a hospital or skilled nursing facility. Discharges include persons who died during their stay or were transferred to another facility.

Early and periodic screening, diagnosis, and treatment (EPSDT)—The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, and health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End stage renal disease—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have end stage renal disease. To qualify for Medicare coverage, such individuals must be fully or currently insured under social security or the railroad retirement system or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the month in which a course of renal dialysis begins. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility or receives a kidney transplant without starting or receiving dialysis.

Enrollment period—Effective October 1, 1981, the general enrollment period for supplementary medical insurance is from January 1 through March 31 of each year. Coverage takes effect July 1. This constitutes a reinstatement of the general enrollment period after a period of continuous open enrollment.

Expenditure—Under Medicaid, an expenditure is an amount paid by a State agency for the covered medical expenses of eligible participants. (For Medicare, see "reimbursement.")

Family planning services—Family planning services are any medically approved means furnished or prescribed by or under the supervision of a physician to individuals of childbearing age for purposes of enabling such individuals freely to determine the number or spacing of their children. Diagnosis, treatment, drugs, supplies and devices, and related counseling are included.

Federal financial participation—Federal expenditures provided to match proper State expenditures made under approved State plans in accordance with the State's Federal medical assistance percentage constitute Federal financial participation.

Federal hospital insurance trust fund—The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by social security. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal supplementary medical insurance trust fund—The Federal supplementary medical insurance (SMI) trust fund is a trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal agent—A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries (for hospital insurance) and carriers (for supplementary medical insurance).

Fiscal year—Fiscal years 1972–76 extended from July 1 through June 30. Beginning with October 1, 1977, fiscal years extend from October 1 through September 30.

General hospital—A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury and for obstetrics.

Health care prepayment plan (HCPP)—In general, members of HCPP's pay regular premiums to the plan. In return, they receive the health services the plan provides without additional charge. Many HCPP's have made arrangements with Medicare to receive direct payments for services they furnish that are covered by supplementary medical insurance.

Health maintenance organization—Some health care prepayment plans provide many inpatient services and therefore have contracts with Medicare as health maintenance organizations. These contracts allow them to receive direct payment for services covered by hospital insurance and supplementary medical insurance.

Home health agency—A home health agency is a public or private organization that provides skilled nursing services and other therapeutic services in the patient's home and that meets certain conditions to ensure the health and safety of the individuals furnished services.

Home health services—Home health services are services and items furnished in patients' homes under the care of physicians. These services are furnished by home health agencies or by others under arrangements made by home health agencies. Services are furnished under a plan established and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

Hospital insurance—Hospital insurance (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related posthospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems, for individuals under age 65 who have been entitled for at least 24 months to disability benefits under the social security or railroad retirement systems, and for certain other individuals who are medically determined to have end stage renal disease and are covered by the social security or railroad retirement systems.

Independent laboratory—An independent laboratory is a laboratory certified to perform diagnostic tests independent of a physician's office or hospital and receive reimbursements from Medicare.

Inpatient hospital services—Inpatient hospital services are items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary—An intermediary is an organization selected by providers of health care that has an agreement with the Department of Health and Human Services to process claims and perform other functions under Medicare's hospital insurance program.

Intermediate care facility—An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

Laboratory and radiological services—Laboratory and radiological services are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime reserve—A Medicare hospital insurance enrollee has a nonrenewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted.

Long-stay hospital—A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically needy—Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children whose income resources are above the limits for eligibility as categorically needy but are within limits set under the Medicaid State plan and who are otherwise eligible for Medicaid.

Other practitioners' services—Other practitioners' services are health care services of licensed practitioners other than physicians and dentists.

Outpatient hospital services—Outpatient hospital services are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient services—Outpatient services are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or freestanding dialysis unit. Such services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Persons served—Under Medicare, a person served is a Medicare enrollee who uses a covered medical service, incurs expenses greater than the deductible amount, and for whom Medicare paid benefits.

Physicians' services—Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-ray—A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium—A premium is a monthly fee paid by Medicare enrollees. Hospital insurance (HI) enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. Supplementary medical insurance enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Premium hospital insurance—Persons 65 years of age or over who are not automatically eligible for hospital insurance may obtain coverage by paying a monthly premium.

Prescribed drugs—Prescribed drugs are drugs dispensed by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs and drugs dispensed by a licensed practitioner to his own patients. Drug charges that are not separable from a practitioner's other charges and drugs covered by a hospital bill are not included.

Prevailing charge—The prevailing charge is the charge at the 75th percentile in an array of the weighted customary charges made for similar services in the same locality. This is the upper limit of charges deemed "reasonable" for Medicare reimbursement.

Prospective payment system (PPS)—PPS is a Medicare system whereby hospitals are paid rates determined in advance for a specific unit of service. Each hospital keeps the difference between the payment rate and its cost, and each hospital is also at risk for any costs incurred above the prospective rate.

Psychiatric hospital—A psychiatric hospital is an institution primarily engaged in providing inpatients psychiatric services for the diagnosis and treatment of mental illness by or under the supervision of a physician.

Railroad retirement system—The railroad retirement system was mandated by the Railroad Retirement Act of 1937 as a retirement system for railroad employees.

Reasonable charge—In processing claims for supplementary medical insurance benefits, carriers use Health Care Financing Administration guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier, the charge the physician or supplier customarily bills patients for the same service, or the prevailing charge which most physicians or suppliers in that locality bill for the same service. Increases in physicians' prevailing charge levels are recognized only to the extent justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable cost—In processing claims for hospital insurance (HI) benefits, intermediaries use Health Care Financing Administration guidelines to determine the reasonable cost incurred by individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the HI program.

Recipient—A Medicaid recipient is an individual who has been determined to be eligible for Medicaid and who has used medical services covered by Medicaid.

Reimbursement—The reimbursement amount includes only the amount shown in bills received and processed by the Medicare program in the Central Office files of the Health Care Financing Administration. Excluded are: interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of fiscal year cost reports, and certain capitation payments for prepaid group health plans. (For Medicaid, see "expenditure.")

Rural health clinic—A rural health clinic is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets certain other requirements designed to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not an urbanized area as defined by the U.S. Bureau of the Census and that is designated by the Secretary of the Department of Health and Human Services either as an area with a shortage of personal health services or as a health manpower shortage area. Rural health clinics must file an agreement with the Secretary not to charge an individual for items or services for which the person is entitled to have payment made by Medicare. An individual is charged only for the amount of any applicable deductible or coinsurance amount.

Short-stay hospital—A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled nursing facility—A skilled nursing facility is an institution that has a transfer agreement with one or more participating hospitals, that is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and that meets specific regulatory certification requirements.

Skilled nursing facility services—All services furnished to inpatients of a certified skilled nursing facility that meets standards required by the Secretary of the Department of Health and Human Services and billed by the facility are included.

Spend-down—Under the Medicaid program, spend-down refers to a method by which an individual establishes Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State buy-in—This is the term given to the process by which a State may provide supplementary medical insurance coverage for its needy eligible persons by paying their premiums through an agreement with the Federal Government.

State plan—The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental Security Income (SSI)—SSI is a program of income support for low-income aged, blind, and disabled persons that was established by Title XVI of the Social Security Act.

Supplementary medical insurance—Supplementary medical insurance (also known as Medicare Part B) is a voluntary insurance program that provides insurance benefits for physicians' and other medical services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of Title XVIII of the Social Security Act. The program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government.

Third-party liability—Under Medicaid, third-party liability exists if there is any entity (including other government programs or insurance) that is liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Utilization and quality control peer review organization (PRO)—PRO is a statewide nonfacility organization. Established by Public Law 97-248 (the Social Security Act of 1983), it is a physician-sponsored or physician-access organization that enters into a contract with the Department of Health and Human Services (DHHS) to conduct utilization and quality control review for services and items that may be paid for by Medicare. PRO's review responsibilities include: admission review (preadmission, preprocedure, and review within 7 days of discharge), review of transfers, permanent cardiac pacemaker implantation review, quality review, diagnosis-related group validation, cost and stay outlier review, admission pattern monitoring, prospective payment system, hospital denial review, reconsiderations, sanctions and review of abuse issues referred by other Medicare contractors, the Health Care Financing Administration, or the DHHS Office of the Inspector General. A hospital agreement with the PRO for PRO performance of utilization and quality control review is a condition of payment under the Medicare prospective payment system. States may contract with a PRO for Medicare review.

Vendor—A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services.

Appendix E
Medicare and Medicaid acronyms

AAPCC	Adjusted average per capita cost
ACRG	Annual compound rate of growth
AFDC	Aid to Families with Dependent Children
AHCCCS	Arizona Health Care Cost Containment System
CFR	*Code of Federal Regulations*
CMHS	Continuous Medicare history sample
CON	Certificate of need
DEFRA	Deficit Reduction Act
DHHS	Department of Health and Human Services
DRG	Diagnosis-related group
EAC	Estimated acquisition cost
EPSDT	Early and periodic screening, diagnosis, and treatment
ESRD	End stage renal disease
FFP	Federal financial participation
FMAP	Federal Medicaid assistance percentage
HCFA	Health Care Financing Administration
HCPP	Health care prepayment plan
HHA	Home health agency
HI	Hospital insurance
HMO	Health maintenance organization
ICF	Intermediate care facility
ICF/MR	Intermediate care facility for the mentally retarded
MAC	Maximum allowable cost
MMIS	Medicaid Management Information System
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OTC	Over-the-counter (drugs)
PPS	Prospective payment system
PRO	Peer review organization
SMI	Supplementary medical insurance
SNF	Skilled nursing facility
SSI	Supplemental Security Income
SSP	State supplemental payment
TEFRA	Tax Equity and Fiscal Responsibility Act

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